NEW YORK STATE OF OPPORTUNITY.

Office for People With Developmental Disabilities

# The Part 624 and Part 625 Handbook

## Part 624 - Reportable Incidents and Notable Occurrences
## Part 625 - Events and Situations

### A Resource for all OPWDD Providers

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Readers should be aware that enforcement of the requirements of Part 624 is only one component of OPWDD's commitment to reducing the number of incidents. OPWDD also has instituted an aggressive campaign to reduce abuse and neglect by strengthening the relationships between the individuals receiving services and those that care for them.

*For further information on the purpose of this Handbook and how to use it, please contact your OPWDD Incident Compliance Officer: https://opwdd.ny.gov/providers/incident-management*

*Forward questions/comments to OPWDD's Incident Management Unit at incident.management@opwdd.ny.gov.*

# SECTION I – Applicability, Background and Intent

624.1 Applicability.

624.1(a) This Part is applicable to all facilities and programs that are operated, certified, sponsored, or funded by OPWDD for the provision of services to persons with developmental disabilities.

Note: Use of the term "agency" throughout the regulation refers to OPWDD Developmental Disabilities State Operations Offices (DDSOOs, see glossary, section 624.20) as well as other non-state agencies (see glossary, section 624.20) and sponsoring agencies (see glossary, section 624.20) that sponsor family care homes.

624.1(b) Intermediate Care Facilities (see Part 681 of this Title), including state operated developmental centers, 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.

624.1(c) The requirements of this Part apply to events and situations that are under the auspices (see glossary, section 624.20) of an agency. Note that requirements concerning events and situations that are not under the auspices of an agency are set forth in Part 625 of this Title.

624.1(d) Programs that are certified under paragraph 16.03(a)(4) of the Mental Hygiene Law and are funded by OPWDD, but that are not operated by OPWDD, are not considered to be “facilities and programs that are certified or operated by OPWDD” as that phrase is used throughout this Part. The requirements of this Part apply to reportable incidents and notable occurrences that are under the auspices (see glossary, section 624.20) of such programs, except that such programs are not required to report incidents to the Justice Center’s Vulnerable Persons’ Central Register (VPCR).

624.1(e) The requirements of Part 624 as revised effective June 30, 2013 are applicable to incidents that occur on and after June 30, 2013. Incidents that occurred prior to June 30, 2013 are subject to the requirements of Part 624 that were in effect at the time the incidents occurred. Note that the requirements of Part 624 as revised effective June 30, 2013 include provisions concerning the release of records pertaining to allegations of abuse that occurred prior to June 30, 2013 (See Section 624.8).

624.2 Background and Intent

624.2(a) It is the intent of this Part to require an incident management system, including the reporting, investigation, review, correction, and monitoring of certain events or situations, in order to protect individuals receiving services (to the extent possible) from harm; ensure that individuals are free from abuse and neglect; and to enhance the quality of their services and care.

624.2(b) A primary function of the reporting of certain events or situations is to enable a governing body (see glossary, section 624.20), 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 and situations can ensure that immediate steps are taken to protect persons receiving services from being exposed to the same or similar risk.

624.2(c) The reporting of certain events or situations in an orderly and uniform manner facilitates identification of trends, whether within a facility or class of facilities, by one or more agencies, or on a statewide basis, which ultimately allows for the development and implementation of preventive strategies.

624.2(d) It is the intent of this Part to require a process whereby those events or situationsthat endanger a person's wellbeing while under the auspices of an agency, whichare defined in section 624.3 of this Part as "reportable incidents," and in section 624.4 as "notable occurrences," are reported, investigated, and reviewed, and protective, corrective, and remedial actions are taken as necessary.

(i) 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.)

(ii) 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.

624.2(e) It is not the intent of this Part to mandate that every potentially harmful event or situation attributable to or involving a person receiving services while under the auspices of an agency, be recorded as a reportable incident or notable occurrence in accordance with this Part.

It is the responsibility of the agency to determine how events or situations involving persons receiving services that are under the auspices of the agency or sponsoring agency, other than reportable incidents and notable occurrences are to be documented, processed, corrected, monitored, and analyzed for trends through the development of policies and procedures that are in compliance with 14 NYCRR, and to develop a mechanism for review to ensure compliance with such policies and procedures.

624.2(f) It is the intent of this Part to require a process whereby the governing body ensures the effectiveness of the identification, recording, investigation, review, and corrective actions with regard to events or situations involving persons receiving services referenced within this Part. This must be achieved through the establishment of the governing body's own protocol, which may include, but not be limited to, regular review of the minutes of the incident review committee and periodic attendance at that committee's meetings.

624.2(g) It is the intent of this Part to hold the governing body and the chief executive officer (see glossary, section 624.20) responsible for the management of incidents. However, the chief executive officer may designate staff members to assume specified responsibilities to facilitate the day to day process, and these designations must be set forth in writing in agency policies and procedures and made known to all staff and others with a need to know.

624.2(h) Though failure on the part of an agency to provide appropriate services may not meet the definition of an incident or notable occurrence as defined in sections 624.3 or 624.4 of this Part, OPWDD has, pursuant to statute, the authority to investigate or cause the investigation of conduct, performance, and/or alleged neglect of duty.

624.2(i) It is the intent of this Part to require a process for facilities that is in full compliance with the provisions of section 29.29 of the Mental Hygiene Law.

624.2(j) Facilities and programs that are certified or operated by OPWDD, except those programs that are certified under paragraph 16.03(a)(4) of the Mental Hygiene Law, are required to comply with relevant provisions of Article 20 of the Executive Law (Protection of People with Special Needs) and Article 11 of the Social Services Law (Protection of People with Special Needs), and to implement regulations promulgated by the Justice Center for the Protection of People with Special Needs (Justice Center).

# SECTION II – Definitions and Commentary

624.3. Reportable incidents, defined.

624.3(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 an agency.

Commentary:

- The following pages explain those incidents that must be reported in accordance with OPWDD's regulations.
- All reportable incidents that occur under the auspices of facilities and programs certified or operated by OPWDD must be reported to the New York State Justice Center for the Protection of People with Special Needs (Justice Center) Vulnerable Person's Central Register (VPCR) at 1-855-373-2122 in accordance with reporting requirements in section 624.5.
- All reportable incidents that occur under the auspices of facilities and programs certified, operated, or funded by OPWDD must be reported to OPWDD in accordance with reporting requirements in section 624.5. https://opwdd.ny.gov/sites/default/files/documents/OPWDD-EmergencyRegs120215Text.pdf

# Part 624 Commentary; Reportable Incidents of Abuse/Neglect, Defined

624.3(b)(1) Physical abuse

> Conduct by a custodian (see glossary, section 624.20) intentionally (see glossary, section 624.20) or recklessly (see glossary, section 624.20) causing, by physical contact, physical injury (see glossary, section 624.20) 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.

Definitions from Section 624.20 and Section 15.05 of NYS Penal Law:

***Intentionally.*** A person acts intentionally with respect to a result or to conduct described by a statute defining an offense when his or her conscious objective is to cause such result or to engage in such conduct.

***Recklessly.*** 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.

***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.

Commentary:

- It is not the reporter's role or responsibility to determine if the conduct he or she witnessed or heard about was intentional or reckless. All ***suspected*** cases of physical abuse must be reported, investigated, and reviewed in accordance with sections 624.5, 624.6, and 624.7 of this Part.

- In order for physical abuse to be substantiated, after the suspected abuse is reported, it must be determined through investigation that the conduct was intentional or reckless in accordance with applicable definitions of these terms.

- In order for physical abuse to be substantiated, the physical contact must cause physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient or cause the likelihood of such injury or impairment. This is defined as any confirmed harm, hurt or damage resulting in a significant worsening or diminution of an individual's physical condition. Improper physical contact may occur that does not meet this standard and therefore does not rise to the level of physical abuse.

- Improper physical contact that does not rise to the level of physical abuse (does not cause physical injury or the likelihood of physical injury) may still be considered employee misconduct and may result in disciplinary action.

- There can be a fine line between proper and improper physical conduct with persons receiving services. It is necessary for staff to be educated in order to distinguish that line and the differences between proper and improper conduct. This can be done through formal training in approved interventions, ongoing discussions and supervision, and the example provided by the appropriate behavior of those in positions of authority and role models.

- A physical altercation between persons receiving services may be reported as a significant incident to the Justice Center (where applicable) and OPWDD if the altercation meets the definition of Conduct between individuals receiving services. These situations do not constitute physical abuse. Staff failure to intervene in these situations could, however, constitute neglect.

- Use of a restraint, when the technique, the amount of force that is used, or the situation in which the restraint is used is inconsistent with a service recipient's individual treatment or behavioral support plan, inconsistent with the techniques and interventions taught through OPWDD approved trainings, generally accepted treatment practices and/or applicable federal or state laws, regulations or policies would be reported as "deliberate inappropriate use of restraints" or "inappropriate use of restraints", not as physical abuse. Refer to 14 NYCRR Section 633.16 Person-Centered Behavioral Intervention, the OPWDD PROMOTE curriculum and the commentary within this handbook about "deliberate inappropriate use of restraints" for more information.

- An action that might otherwise be considered physical abuse but necessary to ensure the safety of any individual would not be filed as physical abuse. For example, an individual is running toward the road where there is traffic and a custodian "grabs" the individual to prevent him or her from running into traffic. If there is any question whether the action taken by the custodian was necessary to ensure the safety of the individual (e.g. a witness to the event reports that he or she did not feel the action was necessary) then a report of physical abuse must be made and investigated in accordance with Part 624.

624.3(b)(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 articles 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.

Note: Links to provisions of the State Penal Law referenced in the definition of "sexual abuse" follow the commentary below.

Commentary:

- Physical contact with sexual or other intimate parts of a person is sometimes necessary dependent upon the level of assistance a person requires. Contact that is not for the purpose of gratifying personal sexual desires of either the custodian or the person receiving services is not considered sexual abuse. Sexual abuse is limited to conduct defined in the Penal Law provisions noted above.

- Sexual contact between individuals receiving services when one of the individuals is not capable of consenting or does not consent to the contact must be reported as a"significant incident" under the categoryof “conduct between individuals receiving services”.

- When sexual contact involves a person receiving services who is not capable of consenting or does not consent to the activity and the contact does not occur under the auspices of the agency (e.g., a person is sexually abused by a family member), the situation must be reported in accordance with Part 625 if it meets the criteria established in that Part.

- In situations reported as “sexual abuse,” the agency must notify local law enforcement authorities, in addition to reporting to the Justice Center (where applicable) and OPWDD.

- Allowing, permitting, using or encouraging any individual receiving services to engage in prostitution or in a sexual performance (if the individual is a child) should be reported as sexual abuse. Other non-contact conduct such as exhibitionism or verbal sexual harassment should be reported as psychological abuse when the conduct involves a custodian or as a “significant incident” when conduct only involves individuals receiving services.

- See Section III of this handbook for links to the section of the NYS Penal Law referred to above.

624.3(b)(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.

Definitions from Section 624.20 and Section 15.05 of NYS Penal Law:

***Intentionally.*** A person acts intentionally with respect to a result or to conduct described by a statute defining an offense when his or her conscious objective is to cause such result or to engage in such conduct.

***Recklessly***. 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.

Commentary:

- Please see *OPWDD Guidelines for the Completion for the Assessment used to determine the effect of Psychological Abuse* (Appendix 1).

- It is not the reporter's role or responsibility to determine if the conduct he or she witnessed or heard about was intentional or reckless. All suspected cases of psychological abuse must be reported, investigated, and reviewed in accordance with sections 624.5, 624.6, and 624.7 of this Part. In order for abuse to be substantiated, after the suspected abuse is reported, it must be determined through investigation that the conduct was intentional or reckless in accordance with applicable definitions of these terms, and there must be an assessment supporting the conclusion that the conduct caused a substantial diminution of the emotional, social, or behavioral development or condition of a person receiving services.

- If it is determined that the conduct did not cause a substantial diminution of the emotional, social or behavioral development or condition of the individual receiving services, the incident would be unsubstantiated as psychological abuse. However, if the conduct constituted a breach of the custodian's

  duty and resulted in or was likely to result in serious or protracted impairment of the physical, mental or emotional condition of an individual receiving services the incident may be substantiated as neglect.

- Exhibitionism or voyeurism by a custodian may be reported as psychological abuse if it meets the definition.

- The title "Behavior Intervention Specialist" applies only to Part 633.16 and the development of behavior support plans or behavioral interventions. Part 624 requires that the clinical assessment of substantial diminution, necessary to substantiate/unsubstantiated psychological abuse, be completed by a "*physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker, or licensed mental health counselor.*" Within the SO sector, professionals working under the title of "psychologist" may complete a clinical assessment of substantial diminution independently although all non-licensed staff do practice under the supervision of a chief psych who is licensed. Within the voluntary sector, the person completing the assessment must function as a "psychologist." In NYS it is required that anyone using the title "psychologist" must be licensed by NYS with the exception of state employed psychologists functioning in a civil service item.

- Within the voluntary sector, the regulation does not prohibit a licensed psychologist from using non-licensed staff, including a BIS, to assist with completing the assessment. The degree of involvement should be determined by the licensed psychologist as any non-licensed staff are practicing under his/her license. For example, a BIS or non-licensed psychologist could assist with data collection, record review, etc. under the direction of a licensed psychologist. The licensed psychologist may have the non-licensed staff draft the assessment findings, however, the actual assessment must be completed and signed by the licensed psychologist as required by the regulation.

624.3(b)(4) Deliberate inappropriate use of restraint

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.

Commentary:

- ***Deliberate inappropriate use of restraints*** and ***Inappropriate use of restraints*** are two separate categories of reportable incidents that must be reported to the Justice Center (where applicable) and to OPWDD. *Deliberate inappropriate use of restraints* is a reportable incident of abuse/neglect. *Inappropriate use of restraints* is a significant incident.

- ***Deliberate*** means willful, purposeful, or conscious; use of the term *deliberate* implies a belief or perception that the custodian has acted *with intent* to engage in an inappropriate use of restraint. If this standard is not met, the incident may be filed as a significant incident under the category *inappropriate use of restraints*.

- There can be a fine line between proper and improper physical conduct with persons receiving services. It is necessary for staff to be educated in order to distinguish that line and the differences between proper and improper conduct. This can be done through formal training in approved interventions, ongoing discussions and supervision, and the example provided by the appropriate behavior of those in positions of authority and role models.

- OPWDD requirements concerning use of restraints can be found in OPWDD regulations at 14 NYCRR Section 633.16 *Person-Centered Behavioral Intervention.* In addition, information about the use of OPWDD approved physical intervention techniques (e.g. manual holds) may be found in OPWDD's PROMOTE or SCIP-R curriculum. Refer to these resources to understand the terminology used in this commentary.

- Deliberate inappropriate use of restraints by a custodian may include:

    - the willful use of any intermediate and/or restrictive physical intervention technique in a manner inconsistent with or contraindicated by the individual's behavior support plan;

    - the willful use of any intermediate or restrictive physical intervention technique when not necessary to protect the individual or others from harm during a behavioral event or in an emergency situation. An emergency situation poses an immediate health or safety risk to the person or to others that is unexpected, unforeseen, or unanticipated, and for which procedures have not been specified in a person's behavior support plan.

- The willful use of any medically contraindicated physical intervention technique, except in an actual emergency and only when necessary to ensure the safety and well-being of an individual. The use of a prone restraint is prohibited and is always considered physical abuse.

- Use of OPWDD approved physical intervention techniques on an emergency basis is not "deliberate inappropriate use" if it is justified by the circumstances, even if it is not part of a behavior support plan.

- The intentional use of medication to modify or control challenging behavior that is not in conformance with the requirements of Section 633.16 is considered deliberate inappropriate use of restraint. This would always include a medication prescribed for a medical reason but is administered to control a person's behavior. An example would be that an individual has a physician's order for Benadryl for allergies. This medication is administered by a direct support professional because the individual is "acting up" and the Benadryl makes the individual sleepy. If a controlled substance is administered similarly it is a reportable incident of Unlawful use or administration of a controlled substance.

- If a mechanical restraining device is used to control a person in a manner that is not in conformance with the requirements of Section 633.16, and is used for staff convenience, for disciplinary purposes or retribution, as a substitute for programming, or as a substitute for supervision, the situation must be reported as deliberate inappropriate use of restraint.

624.3(b)(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.

Commentary:

- Aversive conditioning is prohibited by OPWDD, and therefore, any use would constitute abuseand would be reported as *use of aversive conditioning*.

624.3(b)(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.

Commentary:

- Mandated reporter as defined in Social Services Law (SSL) Section 488 includes custodians in programs certified or operated by OPWDD and a specified list of "human services professionals" defined as (noted below).

- A mandated reporter is defined as a "custodian" or "human services professional."

  - Custodian. For the purposes of section 633.7 only, a party that meets one of the following criteria:

    (1) a director, operator, employee or volunteer of a facility or program which is certified or operated by OPWDD; or

    (2) a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to such facility or program pursuant to contract or other arrangement that permits such party to have regular and substantial contact with individuals receiving services from the facility or program; or

    (3) a family care provider; or

    (4) a family care respite/substitute provider.

  - 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 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.

  - "Human services professional" is defined in the PPSNA as a physician; registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; licensed practical nurse; nurse practitioner; social worker; emergency medical technician; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed psychoanalyst; licensed speech/language pathologist or audiologist; licensed physical therapist; licensed occupational therapist; hospital personnel engaged in the admission, examination, care or treatment of persons; Christian Science practitioner; school official, which includes but is not

Limited to a school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator or other school personnel required to hold a teaching or administrative license or certificate; social services worker; any other child care or foster care.

- Custodians in non-certified services that are not operated by OPWDD are required to report reportable incidents pursuant to the requirements of Part 624, but are not mandated reporters as defined in SSL Section 488 (and are therefore not required to report to the Justice Center). It must be noted that some human service professionals in non-certified settings may be "mandated reporters" because of their occupation and/or professional licensing requirements, thus would report abuse or neglect according to those professional requirements. However, conduct by these custodians may constitute "obstruction of reports of reportable incidents" if they fail to report a reportable incident as required by OPWDD regulations or engage in the other conduct specified in the definition.

- Each mandated reporter in programs operated or certified by OPWDD are required to report reportable incidents to the Justice Center's Vulnerable Persons' Central Register (VPCR). Additional reporting requirements related to reportable incidents are also included in this Part, including the requirement that reports of reportable incidents be submitted to OPWDD.

- Each mandated reporter is required to submit a report of a reportable incident to the VPCR either through calling the VPCR hotline or submitting the NYJC Incident Submittal Web Form at https://vpcr.justicecenter.ny.gov/wi/.

624.3(b)(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.

Commentary:

- Controlled substances are listed in Public Health Law (PHL) §3306 and range from illegal drugs, like non-medicinal marijuana, heroin, and LSD that have no accepted medical use for treatment in NYS, to commonly used prescription drugs, such as Klonopin, Valium, and cough syrup with Codeine.

- Any administration by a custodian to an individual receiving services of a controlled substance without a prescription is considered unlawful administration of a controlled substance

- Custodians must not use controlled substances unlawfully at the workplace or while on duty. This must be reported as unlawful use or administration of a controlled substance.

- Custodians must never unlawfully distribute any controlled substance at the workplace or while on duty. This must be reported as unlawful use or administration of a controlled substance. Distribution of a controlled substance includes both selling and giving the controlled substance to another person. This is not limited to individuals receiving services.

- If a custodian has a prescription for the use of a controlled substance and is taking it in accordance with doctor's orders, this use would not be considered unlawful and would not meet the definition of abuse in this category. A custodian must, however, follow agency policies and procedures on safeguarding medications for personal use and should not be on duty if his or her ability to fulfill job responsibilities is impaired.

- This category is not intended to address the use of legally available herbal supplements and vitamins; these supplements may be administered with a prescription and in accordance with OPWDD regulations at 14 NYCRR section 633.17.

- This provision addresses unlawful use of controlled substances. There is another provision, categorized as a "significant incident," that addresses administration of a prescribed or over-the-counter medication that is inconsistent with a prescription and results in an adverse effect to an individual receiving services.

624.3(b)(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.

Definition from Section 624.20:

***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.

Commentary:

- It is not the custodian's role to determine if the conduct or conditions will result in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the individual receiving services. It is the responsibility of the custodian to report all suspected neglect.
- A pattern of failures to provide one or more individuals with routine medical care or treatment may constitute neglect. Failure to provide medical services that were ordered to address signs and symptoms of a known or suspected medical condition may also constitute neglect.
- When a custodian witnesses, but does not attempt to intervene, during an altercation between two individuals receiving services, a report of neglect may be filed. If the custodian attempts to intervene but is not successful, a report of neglect should not be filed. An altercation between two individuals receiving services may need to be reported as a significant incident "conduct between individuals receiving services."
- If there is documentation that an individual receiving services requires enhanced supervision and that enhanced supervision is not provided it must be reported as neglect.
- If an action or inaction on the part of a custodian does not meet the definition of another classification of abuse but jeopardizes the health and safety of an individual receiving services, it must be reported.
- For example:

- Texting while driving;
- Sleeping on duty by a custodian that leaves the program below the established health and safety minimums; or
- If a custodian is sleeping on duty and an individual is injured; an untoward event occurs, including but not limited to, a physical altercation between individuals receiving services or a choking incident; or an individual is not provided with appropriate supervision.

PRIOR TO JANUARY 1, 2016

624.3(b)(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 prior 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, 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;

*(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.

624.3(b)(9)(ii) **the following types of incidents <u>on and after January 1, 2016</u>:**

624.3(b)(9)(ii)(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

<u>Commentary:</u>

- Please see *OPWDD Guidelines for Responding to Conduct Between Persons Receiving Services that would Constitute Abuse if Committed by a Custodian* (Appendix 2)

| **Decision Matrix for Sexual Contact Involving Persons Receiving Services**<br>(Words in bold italic font represents type of incident per 624) | | |
|---|---|---|
| Characteristics of Involved People | Use of Coercion/force | |
| | Coercion/force was not used | Coercion/force was used |
| Both receive services;<br>Both capable of consent | ***Not an incident*** | ***Reportable Significant-Conduct Between Individuals Receiving Services*** |
| Both receive services;<br>Initiator capable of consent,<br>Other not capable of consent | ***Reportable Significant-Conduct Between Individuals Receiving Services*** | ***Reportable Significant-Conduct Between Individuals Receiving Services*** |
| Both receive services;<br>Initiator not capable of consent,<br>Other capable of consent | ***Reportable Significant-Conduct Between Individuals Receiving Services*** | ***Reportable Significant-Conduct Between Individuals Receiving Services*** |
| Both receive services;<br>Both not capable of consent | ***Reportable Significant-Conduct Between Individuals Receiving Services*** | ***Reportable Significant-Conduct Between Individuals Receiving Services*** |

- The above matrix does not apply to employees of an agency where the people involved are receiving services. Any sexual contact between a person receiving services and an employee, intern, consultant, contractor or volunteer of an agency is always considered to be sexual abuse and is prohibited. A person with a developmental disability who is or who 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. The above matrix does not apply Refer to 624.3(b)(2).

- Failure on the part of a custodian to provide proper supervision for an individual receiving services as required in their plan of care that results in an incident of conduct between persons receiving services is to be reported as a reportable incident of neglect. Refer to 624.3(b)(6)(i).

- An intentional physical interaction between individuals, which results in an injury requiring more than first aid, is a reportable incident, and must be reported to the Justice Center, and OPWDD's Incident Management Unit.

- If a physical interaction between individuals does not rise to the level of a reportable incident, the agency may elect to document the event as an occurrence.

624.3(b)(9)(ii)(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

624.3(b)(9)(ii)(b)(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, 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.

Commentary:

- The use of a time-out room when an individual does not have time-out as an intervention in their Behavior Support Plan, even in an emergency, is considered seclusion. Seclusion is prohibited by OPWDD and must be reported as "seclusion," a significant incident.

- The placement of an individual in any room where the door is locked/secured from the outside and stays locked/secured without staff direct physical continuous action is seclusion.

- The use of a room where an individual cannot leave at will is considered seclusion.

- The use of a room for time-out not designated for time-out use is considered seclusion. For example, the placement of an individual into a coat closet because the time-out room is occupied is considered seclusion and must be reported as a significant incident.

- Requiring an individual to move to a particular location where they are contained and where egress is blocked (e.g., taped off area of the hall, area that staff surround with mats to contain an individual) when the use of such intervention is not prescribed in an approved BSP is seclusion.

| Examples | Seclusion | Unauthorized use of time out |
|---|---|---|
| Use of a time out room when it is not an intervention in the BSP. | X | |
| Individual is restricted to an area where they cannot leave at will and time out is not an approved intervention in their BSP. | X | |
| Use of a time out room when there is no current HRC approval and/or current informed consent for the BSP to use the intervention. | X | |
| An individual is locked in a room. | X | |
| The use of a room such as a bedroom or a laundry room for time out; regardless of whether the individual has time out included in a BSP. | X | |
| The use of a time out room for time exceeding that prescribed in the current BSP. | | X |
| Placing a person in time out when they are exhibiting a behavior in their BSP but time out is not the intervention for that behavior. | | X |
| An individual becomes agitated and is required to sit in the hall where staff prevent the individual from leaving the area. The individual does not have a BSP. | X | |

624.3(b)(9)(ii)(b)(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.

Commentary:

- The following circumstances do not constitute *unauthorized use of time out*:
  - An individual receiving services goes into a time-out room voluntarily and independently and sits down. The staff member ensures that egress is not blocked, provides ongoing visual and auditory monitoring of the individual, and encourages the individual to use their self-soothing or calming techniques. The staff member encourages the individual to continue programming when he or she expresses a desire to leave the room.
  - A staff member encourages an individual, who is becoming upset, to take a walk to the individual's personal space, such as a bedroom, where the staff member and individual discuss how the individual is feeling and how they can appropriately address theproblem.
  - An individual goes to their bedroom, locks the door, and listens to music. This is not *unauthorized use of time-out* as the individual can unlock the door and leave the room at will.

- Situations in which an individual refuses to leave the time-out room after an hour of authorized time-out should not be filed as *unauthorized use of time-out*. However, in such circumstances, staff must ensure that the individual has the ability to leave the room at will and that the person is not denied the opportunity for reinforcement.

- The use of time-out in any way other than as specified in the person-centered BSP constitutes *unauthorized time-out*. The following are examples of unauthorized time out:
  - Staff failing to attempt less restrictive or intrusive interventions, as outlined in the BSP and when safety permits, prior to placement in time-out constitutes unauthorized time-out.
  - Requiring an individual to remain in time-out for twenty minutes once the challenging behavior has ceased when their plan requires that the individual be released from time-out after five minutes of no challenging behavior constitutes *unauthorized use of time-out*.

- It is not *unauthorized use of time-out* when an individual is in the time-out room for the maximum amount of time prescribed in the BSP, leaves, but must be escorted back to the time-out room due to challenging behavior.

| Examples | Seclusion | Unauthorized use of time out |
|---|---|---|
| Use of a time out room when it is not an intervention in the BSP. | X | |
| Individual is restricted to an area where they cannot leave at will and time out is not an approved intervention in their BSP. | X | |
| Use of a time out room when there is no current HRC approval and/or current informed consent for the BSP to use the intervention. | X | |
| An individual is locked in a room. | X | |
| The use of a room such as a bedroom or a laundry room for time out; regardless of whether the individual has time out included in a BSP. | X | |
| The use of a time out room for time exceeding that prescribed in the current BSP. | | X |
| Placing a person in time out when they are exhibiting a behavior in their BSP but time out is not the intervention for that behavior. | | X |
| An individual becomes agitated and is required to sit in the hall where staff prevent the individual from leaving the area. The individual does not have a BSP. | X | |

624.3(b)(9)(ii)(b)(3) Medication error with adverse effect

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;

Commentary:

- Medication errors requiring medical treatment and/or monitoring resulting in a negative effect on an individual's physical condition would be considered a "medication error with adverse effect".

- If errors involving medication do not meet the definition of a medication error with adverse effect as defined in Part 624, the agency is to ensure that the errors are recorded and addressed appropriately according to agency policy.

  Examples:

  - Aspirin is administered as ordered for an individual receiving services and the individual receiving services develops a slight rash. This would not be a medication error with adverse effects. However, it should be reported within the agency, reviewed, and monitored according to agency policy/procedure.

  - An individual receiving services has a seizure disorder and receives medication daily to control his/her seizures. If the seizure medication is not administered or the administration is late, and the person experiences a seizure, this would be considered a reportable incident, medication error with adverse effect.

  - An individual receiving services is given an incorrect medication and/or incorrect dosage of medication. The individual presents marked lethargy and is taken to the hospital for observation. This situation would be an incident, medication error with adverse effect.

624.3(b)(9)(ii)(b)(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

Commentary:

- ***Inappropriate use of restraints*** and ***Deliberate inappropriate use of restraints*** are two separate categories of reportable incidents that must be reported to the Justice Center (where applicable) and to OPWDD. *Inappropriate use of restraints* is a significant incident. *Deliberate inappropriate use of restraints* is a reportable incident of abuse/neglect.
- Inappropriate use of restraints by a custodian, that does not constitute deliberate inappropriate use of restraint, may include:
  - the use of any intermediate and/or restrictive physical intervention technique in a manner inconsistent with or contraindicated by the individual's behavior support plan;
  - the use of any intermediate and/or restrictive physical intervention technique when not necessary to protect the individual or others from harm during a behavioral event or in an emergency situation. An emergency situation poses an immediate health or safety risk to the person or to others that is unexpected, unforeseen, or unanticipated, and for which procedures have not been specified in a person's behavior support plan.
  - The use of any medically contraindicated physical intervention technique, except in an emergency and only when necessary to ensure the safety and well-being of an individual; or
  - the use of any intermediate and/or restrictive physical intervention over the written objection of a parent, guardian or other designated surrogate, except in an emergency.
- There can be a fine line between proper and improper physical conduct with persons receiving services. It is necessary for staff to be educated in order to distinguish that line and the differences between proper and improper conduct. This can be done through formal training in approved interventions, ongoing discussions and supervision, and the example provided by the appropriate behavior of those in positions of authority and role models.
- OPWDD requirements concerning use of restraints can be found in OPWDD regulations at 14 NYCRR Section 633.16 Person-Centered Behavioral Intervention. In addition, information about the use of approved physical intervention techniques (e.g. manual holds) may be found in OPWDD's PROMOTE or SCIP-R curriculum. Refer to these resources to understand the terminology used in this commentary.
- In those cases when restrictive physical interventions permitted through OPWDD's PROMOTE or SCIP-R curriculum are used in an emergency situation, notifications must be made as required by Part 633.16(j)(1)(ix). In addition, the person's program planning or treatment team must be notified to determine whether changes to the individual's current plan, or perhaps development of a new plan, is necessary.

624.3(b)(9)(ii)(b)(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.

Commentary:

- Mistreatment maybe an action or inaction by a custodian that does not meet the definition of Abuse or Neglect or any other type of significant incident, but may have a negative effect on the individual's wellbeing.
- The failure to provide programming, socialization, recreation, etc., may be categorized as mistreatment if it impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services.
- Not every instance or failure to follow an individual's plan of care and accepted treatment practices constitutes mistreatment. Each situation must be reviewed individually.
- Action or inaction by anyone other than a custodian does not constitute mistreatment.

624.3(b)(9)(ii)(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;

Commentary:

- If an individual who is a potential risk to himself or herself cannot be located, then a Missing person at risk for injury must be reported. A person at risk is a person who is not safe alone in the community.
- If person's plan required a specific supervision level, and that supervision level was breached, the missing person incident may need to be upgraded to a report of neglect.
- It is necessary to implement the agency's formal search procedures when a person is missing and at risk for injury.
- Every agency must have written formal search procedures for each of its facilities. The determination of when formal search procedures for a person receiving services are initiated is defined by each agency using knowledge of that person's risks, capabilities, and supervision needs.

*(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.

Examples:

- An individual who regularly returns home at 4:30 pm is not back to his or her residence at 5:00 pm. This circumstance might not rise to the level of a Missing person at risk for injury as the individual has community skills and is not at risk to himself or herself in the community, but at times gets distracted, stopping at stores on his or her return home.
- If an individual leaves a residence or program and staff are able to accompany or follow the individual at all times, this is not required to be reported in accordance with the OPWDD Part 624 process because the person is not missing. This circumstance should be managed in accordance with the individual's plan of care.
- If a person is unexpectedly at another location that is known to staff, this does not necessitate a Missing person at risk for injury report in conformance with Part 624. It may be appropriate, however, to record the circumstance in the person's record and to monitor the behavior, and/or revise the individual's plan as appropriate.
- An individual unexpectedly leaves his or her residence. A staff member follows the individual but loses sight of the individual after 10 minutes. The individual has no safety skills, and is therefore at risk when alone in the community. This must be reported as a Missing person at risk for injury.
- An individual who has a current diagnosis of diabetes who is able to navigate the community but has not returned to receive insulin coverage may be at risk for injury. If a nurse or health care professional deems the individual at risk for injury due to missing the medication dose, the incident should be reported as a Missing person at risk for injury.
- An individual who is unable to independently safely navigate in the community cannot be located at his or her workshop/program, a Missing person at risk for injury incident must be reported. Staff notice that a particular individual who is at risk for injury to himself is not in the home.
- Search procedures begin immediately and include staff searching outside of the home and in the local vicinity. The individual is found outside fifteen minutes later unharmed. This situation is reported in accordance with Part 624 even though the report is made after the individual was found.

624.3(b)(9)(ii)(d) Unauthorized absence.

The unexpected or unauthorized absence of a person after formal search procedures (see glossary, section 624.20) 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;

Commentary:

- An Unauthorized Absence involve individuals who have community safety skills and is reported only after formal search procedures have been initiated.

(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.

- If the individual is a risk to him/herself then the incident is always reported as a Missing Person.

Examples:

- An individual travels to program independently from his/her residence on the public bus and does not arrive at day program at the regular start time. The individual has been known to stop at the park prior to program and arrive at program before lunchtime. This would not automatically become an "Unauthorized Absence". The person would be an "absentee," and the day program should follow-up to the extent required in its own practices. An incident would be reported if the individual's whereabouts are unknown for a period of time outside his/her norm. When formal search procedures are deemed necessary to be initiated, an Unauthorized Absence should be reported.
- An individual with community skills leaves his/her residence in an agitated state against staff's advisement. Staff are unable to follow him/her. The individual has been known to become physically assaultive when agitated. Due to the individual's mental health status, he/she may pose a risk to others in the community. Formal search procedures should be initiated and this incident handled as an Unauthorized Absence.
- An individual can remain in the community for up to four hours independently. The individual goes to the mall but does not return to the residence at the end of the four-hour period. Staff are unable to reach the individual by cellular phone and initiate formal search procedures. This incident should be handled as an Unauthorized Absence.
- The same situation as above, however, staff are able to reach the individual by his/her cellular phone. The individual had lost track of time and meet the staff. He/she was 15 minutes outside the allotted four-hour community access timeframe. Formal search procedures were not initiated. This situation should not be handled as an Unauthorized Absence. It may be prudent to discuss this situation with the individuals' team to reduce the likelihood of it occurring again.

624.3(b)(9)(ii)(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;

Commentary:

- There is a known risk of choking if there is documentation noting an individual's risk such as:
    - History of choking events or aspiration identified in any component of the person's service plan;
    - The person has a prescribed, modified food/beverage size, consistency, pacing due to or based on a documented risk of choking;
    - The person has a history of or is experiencing a diagnosed aspiration pneumonia;
    - The person has had a swallowing evaluation which finds that aspiration or choking is a risk;
    - A medical assessment includes regurgitant symptoms or diagnosis of GERD and specifies that choking is a risk;
    - The service plan includes a type of supervision and/or assistance required during eating/drinking due to a risk of choking; such as the person's pace or amount.

- Choking occurs when a person's airway becomes fully or partially blocked by food, liquid or other objects.

  The following are examples which may be signs of a choking event:
    - showing distress/panic and/or grabbing neck/throat displaying the universal sign for choking;
    - the person's skin/lips turn blue and they are unable to speak or cough; loss of consciousness may occur;
    - coughing in and of itself may not constitute choking, but the individual should be monitored for signs of distress or choking.
    - The following may also be signs of choking:
    - the person may run away instead of toward help;
    - a person may have last consumed food or drink earlier than the episode but experiences choking later, due to regurgitating the food/drink. This is still choking.

- After any choking incident, it is the best practice to have the individual examined by a medical professional.

- Refer to OPWDD website for Health and Safety Alerts and Safeguarding Alerts for more information on choking prevention and intervention.

624.3(b)(9)(ii)(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;

Commentary:

A person is considered to have no known risk of choking if the person:

- does not have a documented history of choking or aspiration
- does not have a modified consistency diet due to a swallowing disorder or other documented risk of choking;
- does not have a service plan including intervention to address rapid eating or food seeking behavior or other risk of choking.

624.3(b)(9)(ii)(g) Self-abusive behavior, with injury.

A self-inflicted injury to an individual receiving services that requires medical care beyond first aid;

Commentary:

- The definition of the term "treatment, requiring medical or dental" in this subdivision is found in the glossary and is as follows:

  Section 624.20

  (ak) For the purpose of this part, a situation in which a person who, by virtue of his or her condition as a result of an injury, 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 an agency's policy and procedure may direct that a person who is in any way injured or has suffered any ill effects is to see a medical professional, even though first-aid has adequately addressed the injury, this does not always constitute requiring medical or dental treatment in terms of defining a notable occurrence.

- The use of dermabond or steri-strips is not considered more than first aid.

- Stitches, sutures and staples are all treatment beyond first aid.

  - The following must be filed as self-abusive behavior, with injury:

    - a person receiving services kicks the wall in an attempt to injure themselves and breaks a bone in their toe; the injury must be reported to ensure proper follow-up occurs to address any medical, environmental, or potential causes.

    - A person has a soft tissue injury (contusion, bruise) which resulted from self-injurious behavior and is examined by a healthcare professional. The diagnosis by the healthcare professional is a sprain. However, an MRI is subsequently completed and reveals a fracture.

    - An individual throws themselves into their dresser and injures their shoulder and an x-ray is negative for fracture. However, the physician prescribes Oxycodone 500mg for pain which requires a prescription.

- Part 624 is exclusively focused on incidents as they affect individuals receiving services. It may happen that employees may be injured due to the aggressive behavior of a person or in some other way related to workplace violence. In general, like other employee injuries, this would not be reported in the Part 624 process, but would be handled through the workers' compensation and insurance process at the agency, and/or other required reporting processes. The New York State Workplace Violence Prevention Law (Section 27-b of the Labor Law) also addresses this issue in state worksites.

624.3(b)(9)(ii)(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;

Commentary:

- Every injury, no matter how slight, must be responded to and treated by a nurse, physician, etc. when appropriate. This does not necessarily mean that the injury must be reported as an incident. Agencies must consider the severity of the injury and the resulting necessary care when determining whether the injury is to be classified as a reportable incident.

- Pursuant to Section 633.10(a)(4), the agency must notify the individual's parent, guardian or correspondent/advocate every time a health problem, symptoms, or condition results in emergency room/urgent care services or admission to a hospital or infirmary.

- If an injury required medical treatment (a "minor notable" injury) and resulted in the person being admitted to a hospital or any other type of 24-hour treatment facility, whether for further treatment or observation, the injury is considered to be an Injury, with hospital admission.

- Symptoms or a diagnosis of an Illness (including mental illness) is not in and of itself a reportable incident. Hospitalization for a health-related problem or condition (e.g., seizures, blood pressure, psychotic episode, pneumonia) does not constitute a reportable incident as this involves an increase of symptoms of a condition rather than an injury.

- If a person fell related to a medical problem (e.g., during a seizure), and was admitted to the hospital for a possible concussion from the fall, this would constitute an Injury, with hospital admission. However, if they were admitted to a hospital due to the seizure only (not the injury), this would not constitute an *Injury, with hospital admission*. If agency review of the situation indicates possible neglect, the neglect is to be reported as a potential reportable incident.

- Part 624 is exclusively focused on incidents as they affect individuals receiving services. It may happen that employees may be injured due to the aggressive behavior of a person or in some other way related to workplace violence. In general, like other employee injuries, this would not be reported in the Part 624 process, but would be handled through the workers' compensation and insurance process at the agency, and/or other required reporting processes. The New York State Workplace Violence Prevention Law (Section 27-b of the Labor Law) also addresses this issue in state worksites.

624.3(b)(9)(ii)(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 $100.00; 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;

Commentary:

- Law enforcement must be notified anytime a crime may have been committed against an individual by a custodian. See 624.6(d)(2)(i)(ii)

  Examples of Theft and Exploitation filed in this classification are:

  - During a scheduled audit of personal allowance ledgers, it is discovered that deposits into individual's accounts are less than the amounts listed on the check stub for deposit. The agency suspects theft by a staff member. The total amount of money missing is over $100.00.

  - An individual is accompanied by a staff member to purchase some groceries they would like. While at the store, the staff member adds several additional items to the cart and pays for them with the individual's benefit card. These items are brought to the staff member's car and not to the IRA. The total for these groceries is $56.89.

  - An individual's video game system is missing and the agency believes it has been stolen. If the replacement value is more than $100.00.

624.3(b)(9)(ii)(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

Commentary:

Incidents that are reportable to the Justice Center, but do not appropriately meet the definition of any other significant incidents.

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 definitions 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) 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 clause 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) 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 subparagraph 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 clause 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 $15.00 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.

(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 $100.00; 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.

*(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 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.

*(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.

**624.4(2) the following types of incidents on and after January 1, 2016:**

624.4(2)(i) Serious Notable Occurrences:

624.4(2)(i)(a) Death.

The death of any person 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;

Commentary:

- All deaths, regardless of the reason for the death, are to be considered serious notable occurrences and reviewed by, at least, the committee that reviews incidents. This is in addition to any other medically oriented/constituted Committee within the agency organizational structure that may also be charged with the responsibility.

- A mortality review does not suffice as an investigation of a death.

- The Justice Center's Death Reporting Line must be contacted for all deaths of individuals receiving certified facility based services.

- If an individual receives MSC services and attends a certified facility based day program and the individual passes away at home unrelated to any issue at that certified program the death should be reported under Part 625. However, since the individual received a certified facility based service it must also be reported to the Justice Center's Death Reporting Line.

- If an individual receiving services dies and it is suspected there was abuse or neglect on the part of a custodian, a report of the abuse or neglect must be made to OPWDD. For programs certified or operated by OPWDD, a report must also be made to the VPCR.

- The report of Death Form must be completed in IRMA within five working days from the date of occurrence or discovery of the death for both Part 624 and Part 625 deaths.

- In certain instances, MHLS must be notified of the death of an individual who is a Willowbrook Class Member; see *Guidelines for Willowbrook Incident Reporting* (Appendix 4). There is no requirement that an agency report the death of any other individual receiving services to MHLS.

624.4(2)(i)(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.

Commentary:

- This is not intended to be a "catch-all" category for events or circumstances that are perceived as not fitting neatly into other categories; if the event or circumstance meets the definition of one of the other categories of incidents, it is to be reported under that classification only.

- The intention of reporting an incident in this category is to make administrators aware that a situation related to an individual receiving services occurred and to provide information to OPWDD.

- There may be circumstances that are not related to a person receiving services that may need to be brought to the attention of the agency administration or OPWDD such as possible staff involvement in a criminal act not related to an individual receiving services. Such reports should be made, but not through the Part 624 process.

624.4(2)(ii) Minor Notable Occurrences

624.4(2)(ii)(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 $15.00 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; and

Commentary:

- It should be noted that law enforcement must be notified anytime a crime may have been committed against an individual by a custodian. See 624.6(2)

- If a theft or financial exploitation involves the use of a credit, debit, or public benefit card, it is always to be reported as a serious notable occurrence.

624.4(2)(ii)(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) by a physician, dentist, physician's assistant, or nurse practitioner, and such treatment is more than first aid.

Commentary:

- The definition of the term "treatment, requiring medical or dental" in this subdivision is found in the glossary and is as follows:

  Section 624.20

  (ak) For the purpose of this part, a situation in which a person who, by virtue of his or her condition as a result of an injury, 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 an agency's policy and procedure may direct that a person who is in any way injured or has suffered any ill effects is to see a medical professional, even though first-aid has adequately addressed the injury, this does not always constitute requiring medical or dental treatment in terms of defining a notable occurrence.

- If it is medically acceptable to treat an injury solely with first aid procedures, the injury is not a minor notable occurrence even if the first aid is provided by a medical professional.

- The administration of any over-the-counter drugs, including the application of commonly used over-the-counter topical medications, the use of antiseptic cleansers, and medication in the dosage prescribed that is available over-the-counter are considered "first aid," even if a physician or dentist writes a prescription for such. If it is unknown if a medication at the dosage prescribed is available over-the-counter or requires a prescription, then ask a pharmacist.

- The administration of a tetanus booster is not considered more than first aid treatment even if ordered (prescribed) by a physician.

- The use of dermabond or steri-strips is not considered more than first aid.

- Stitches, sutures and staples are all treatment beyond first aid and a minor notable occurrence must be reported.

- When a diagnostic procedure (e.g. x-ray, CT scan) reveals a positive finding for an injury (e.g. fracture) even when no treatment beyond first aid is required, it is a *minor notable occurrence.*

  - For example:
    - a person falls and fractures a rib. It is unlikely that medical treatment beyond first aid will be provided; however, a minor notable occurrence must be reported to ensure proper follow-up occurs to address any medical, environmental, or potential causes.

    - An individual has a soft tissue injury (contusion, bruise) and is examined by a healthcare professional. The diagnosis is sprain and no more than first aid is provided. This is not a minor

notable occurrence. However, an x-ray is subsequently completed and reveals a fracture. A *minor notable occurrence* must be reported.

- An individual falls and an x-ray is negative for fracture. However, the physician prescribes Ibuprofen 800mg for pain. A *minor notable occurrence* must be reported because the pain medication is only available by prescription.

- An individual sustains a small laceration and does not require treatment beyond first aid. This is not a *minor notable occurrence*. Later, the individual develops an infection and is prescribed an oral antibiotic such as Penicillin. A *minor notable occurrence* must then be reported.

624.5. Reporting, recording, and investigation.

624.5(a) Policies and Procedures.

(1) Every agency must develop policies and procedures that are in conformance with this Part to address:

(i) reporting, recording, investigation, review, and monitoring of reportable incidents and notable occurrences;

(ii) identification of reporting responsibilities of employees, interns, volunteers, consultants, contractors, and family care providers; and

(iii) providing notice to all employees which states that:

*(a)* all reportable incidents, including reports of abuse and neglect, must be investigated; and

*(b)* if an employee leaves employment prior to the conclusion of a pending investigation, the investigation must continue until it is completed and (for reports of abuse and neglect) a finding is made of substantiated or unsubstantiated.

Commentary:

- Agencies must develop policies and procedures related to incident management in accordance with the requirements as set forth in Part 624. Agency policy may be more restrictive than Part 624, but it can never be less restrictive. Policies and/or procedures need to be developed to cover situations when services are being delivered in a non-certified setting.

- Part 624 must be used as the basis for any agency to make the differentiation between those events which will be reported as reportable incidents, notable occurrences or those which will not be required to be reported as such, but which may be reported as *agency internal occurrences.*

- All mandated reporters for programs certified or operated by OPWDD must report to the NYS Justice Center and OPWDD Incident Management Unit (IMU) whenever there is a reasonable cause to suspect that a reportable incident has occurred.

- All providers of services (voluntary providers and DDSOOs) are responsible for making appropriate notifications to the OPWDD IMU.

624.5(a)(2) Agency policies and procedures,

whether newly developed or representing change from previously approved policies, must be subject to approval by the agency's governing body.

Commentary:

- The governing body (and chief executive officer) have the ultimate responsibility for ensuring that the incident reporting process is in compliance with Part 624.
- OPWDD has the right to review any agency policies related to the incident reporting process to ensure they are consistent with Part 624, or any other applicable regulation.
- The governing body should review and approve policies related to reportable incidents and notable occurrences. Given its overall management responsibilities, it would be appropriate for the governing body to establish its own protocols relative to this matter.

624.5(a)(3) Notification of policies and procedures.

(i) Upon commencement of service provision, and annually thereafter, an agency must offer to make available written information, developed by OPWDD in collaboration with the 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, section 624.20) or advocates (see glossary, section 624.20), unless a person is a capable adult who objects to their notification. The agency must also offer to make available a copy of OPWDD's Part 624 regulations. In order to satisfy this requirement the agency shall:

(a) provide instructions on how to access such information in electronic format and;

(b) upon written request, provide paper copies of such information.

Commentary:

- An incident management process cannot be effective unless all parties involved are aware of the agency's policies and/or procedures to be followed. Agencies must offer to make information available annually.

- When services are provided to persons in either certified or non-certified settings, to avoid conflict or problems at a later date, individuals receiving services family, advocates and representatives should be advised of the policies and procedures of the agency relative to reporting situations that meet the definition of a reportable incident or notable occurrence.

(ii) Upon employment or initial volunteer, contract, or sponsorship arrangements, and annually thereafter, an agency must make the agency's policies and procedures on incident management known to agency employees, interns, volunteers, consultants, contractors, and family care providers. For parties who are required to be trained, this information must be provided in conjunction with training conducted in accordance with section 633.8 of this Title.

(iii) In accordance with section 633.7 of this Title, custodians with regular and direct contact in facilities and programs operated or certified by OPWDD must be provided with the code of conduct adopted by the Justice Center.

624.5(b) General reporting requirements.

(1) All agency 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.

(2) Internal agency reporting.

(i) All minor notable occurrences, as defined in section 624.4 of this Part, must be reported to the agency's chief executive officer (or designee) within 48 hours upon occurrence or discovery.

(ii) All reportable incidents, as defined in section 624.3 of this Part, and serious notable occurrences, as defined in section 624.4 of this Part, must be reported to the agency's chief executive officer (or designee) immediately upon occurrence or discovery.

Commentary:

- Upon occurrence or discovery of an incident, the primary responsibility of staff is to ensure the safety of individuals receiving services. Immediately thereafter, the reporting process is to begin. It is the agency's responsibility to give staff clear directions on the reporting process through its own policies and procedures.

- By definition, the chief executive officer also includes a designee, who must be a senior staff person.

624.5(c) Immediate reporting to OPWDD.

(1) All reportable incidents and serious notable occurrences must be reported immediately to OPWDD in the manner specified by OPWDD.

(2) Immediate entry of initial information into the OPWDD Incident Report and Management Application (IRMA) does not satisfy the reporting requirement in paragraph (1) of this subdivision.

(3) Immediate reporting of reportable incidents to the VPCR (where applicable) does not satisfy the requirement to immediately notify OPWDD of these incidents in accordance with paragraph (1) of this subdivision.

Commentary:

- All reportable incidents and serious notable occurrences must be reported immediately to OPWDD IMU. Voluntary provider agencies and DDSOOs must make notifications to OPWDD IMU by telephone. Notifications must include all pertinent information including a detailed description of the incident and all protections. A phone number where IMU staff may call to reach an agency representative if necessary must also be included.

- During business hours agencies are to call their agency's OPWDD Incident Management Compliance Officer or the OPWDD IMU main number 518-473-7032. The list of OPWDD IMU staff is found on the incident management page of the OPWDD website.

- The OPWDD IMU has off hours staff available to receive notifications between the hours of 4:00 pm and 8:00 am on working days and at all times during nonworking days. The toll free off hours notification line phone number is: 1-888-479-6763.

624.5(d) Reporting of reportable incidents to the Vulnerable Persons' Central Register (VPCR).

(1) Facilities and programs that are operated or certified by OPWDD must report all reportable incidents to the VPCR. (Non-certified programs that are not state operated, and programs certified under paragraph 16.03(a)(4) of the Mental Hygiene Law that are not state operated, are not required to report to the VPCR.)

(2) All custodians (see glossary, section 624.20) in facilities or programs operated or certified by OPWDD are "mandated reporters" and are required to report reportable incidents to the VPCR.

(3) All custodians in facilities or programs operated or certified by OPWDD must submit reports of reportable incidents to the VPCR immediately upon discovery of the reportable incident.

Commentary:

- Immediately means right away. Guidance issued by the Justice Center allows that immediate reporting may be delayed to take the necessary steps to call 9-1-1, implement protections for individuals receiving services, and to follow internal facility procedures. No internal procedure should significantly delay a report to the Justice Center. Staff going "off-duty" does not justify a delay in reporting.

(i) For purposes of this Part, "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.

(ii) Reports must 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.

Commentary:

- The toll free Vulnerable Persons Central Register (VPCR) hotline number is: 1-855-373-2122
- For additional information on reporting to the Justice Center please go to the Justice Center website at www.justicecenter.ny.gov

(iii) Mandated reporters shall have the rights and responsibilities established by section 491 of the social services law.

Commentary:

- Mandated reporter as defined in Social Services Law (SSL) Section 488 includes custodians in programs certified or operated by OPWDD and a specified list of "human services professionals" noted below.

- A mandated reporter is defined as a "custodian" or "human services professional."

  - Custodian. A party that meets one of the following criteria:

    (1) a director, operator, employee or volunteer of a facility or program which is certified or operated by OPWDD; or

    (2) a consultant or an employee or volunteer of a corporation, partnership, organization or governmental entity which provides goods or services to such facility or program pursuant to contract or other arrangement that permits such party to have regular and substantial contact with individuals receiving services from the facility or program; or

    (3) a family care provider; or

    (4) a family care respite/substitute provider.

  - "Human services professional" is defined in the PPSNA as a physician; registered physician assistant; surgeon; medical examiner; coroner; dentist; dental hygienist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; licensed practical nurse; nurse practitioner; social worker; emergency medical technician; licensed creative arts therapist; licensed marriage and family therapist; licensed mental health counselor; licensed psychoanalyst; licensed speech/language pathologist or audiologist; licensed physical therapist; licensed occupational therapist; hospital personnel engaged in the admission, examination, care or treatment of persons; Christian Science practitioner; school official, which includes but is not limited to a school teacher, school guidance counselor, school psychologist, school social worker, school nurse, school administrator or other school personnel required to hold a teaching or administrative license or certificate; social services worker; any other child care or foster care.

- Custodians in non-certified services that are not operated by OPWDD are required to report reportable incidents pursuant to the requirements of Part 624, but are not mandated reporters as defined in SSL Section 488 (and are therefore not required to report to the Justice Center). It must be noted that some human service professionals in non-certified settings may be "mandated reporters" because of their occupation and/or professional licensing requirements, thus would report abuse or neglect according to those professional requirements as well as comply with OPWDD regulations pertaining to incident reporting.

- Custodians of voluntary agencies providing waiver services in the community which are not part of a certified facility's program are not required to report to the Justice Center.

- Each mandated reporter in programs operated or certified by OPWDD are required to report reportable incidents to the Justice Center's Vulnerable Persons' Central Register (VPCR). Additional reporting requirements related to reportable incidents are also included in this Part, including the requirement that reports of reportable incidents be submitted to OPWDD.

624.5(e) Reporting deaths.

(1) 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, must be reported to the Justice Center. Specifics of the reporting requirement are as follows:

(i) The initial report must be submitted by the agency's chief executive officer or designee to the Justice Center death reporting line, in a manner specified by the Justice Center.

(ii) (The death must be reported immediately upon discovery and in no case more than twenty-four hours after discovery.

(iii) Subsequent information must be submitted to the Justice Center, by submission of the *Report of Death* in IRMA within five working days of discovery of the death.

(iv) The results of an autopsy, if performed and if available to the agency, must be submitted to the Justice Center and OPWDD, 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.)

Commentary:

See *Guidance Documents* (Appendix 5) *Part 624 OPWDD and JC Death Reporting Requirements*.

(2) All deaths that are reported to the Justice Center must also be reported to OPWDD.

(i) A death that occurred under the auspices of an agency (see paragraph (4) of this subdivision) must be reported as a serious notable occurrence in accordance with this Part (see also paragraph (3) of this subdivision).

(ii) 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) must be reported in accordance with Part 625 of this Title.

Commentary:

See *Guidance Documents* (Appendix 5) *Part 624 OPWDD and JC Death Reporting Requirements*.

(3) 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 (see paragraph (4) of this subdivision), must be classified as a serious notable occurrence, and reported and managed as such, in accordance with the requirements of this Part

Commentary:

See *Guidance Documents* (Appendix 5) *Part 624 OPWDD and JC Death Reporting Requirements*.

(4) A death is considered to have occurred under the auspices of an agency if:

(i) the individual was living in a residential facility operated or certified by OPWDD, including a family care home (but excluding free standing respite facilities), at the time of his or her death, or if the death occurred up to thirty days after the individual was discharged from the residential facility (unless the person was admitted to a different residential facility in the OPWDD system in the meantime);

(ii) the individual's death occurred during a stay at an OPWDD certified or operated free standing respite facility or was caused by a reportable incident or notable occurrence, defined in sections 624.3 and 624.4 of this Part, that occurred at the facility within thirty days of discovery of the death; or

(iii) the individual had received non-residential services operated, certified, or funded by OPWDD, and

*(a)* the death occurred while the individual was receiving services; or

*(b)* the death was caused by a reportable incident or notable occurrence, defined in sections 624.3 and 624.4 of this Part, that occurred during the provision of services within thirty days of discovery of the death.

Commentary:

See *Guidance Documents* (Appendix 5) *Part 624 OPWDD and JC Death Reporting Requirements*.

(5) If more than one agency provided services to the individual, there must 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 must be the provider of the services to the individual (or sponsoring agency) in the order stated:

(i) OPWDD certified or operated residential facility, including a family care home, but not a free-standing respite facility;

(ii) (ii)OPWDD certified or operated free standing respite facility, if the death occurred during the individual's stay at the facility, or was caused by a reportable incident or notable occurrence defined in sections 624.3 and 624.4 of this Part, that occurred during a stay at the facility within thirty days of discovery of the death;

(iii) 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 of service on a regular basis);

(iv) MSC or PCSS (only OPWDD operated services report to the Justice Center);

(v) HCBS Waiver services (only OPWDD operated services report to the Justice Center);

(vi) Care at Home Waiver services (only OPWDD operated services report to the Justice Center);

(vii) Article 16 clinic services;

(viii) FSS or ISS (only OPWDD operated services report to the Justice Center);

(ix) Any other service operated by OPWDD.

(x) Notwithstanding any other requirement in this paragraph, there may be circumstances in which the death of an individual who resided at a certified residential facility, was staying at a certified free-standing respite facility, or attended a certified day program was caused by a reportable incident or notable occurrence that occurred under the auspices of another OPWDD certified, operated, or funded program or service within thirty days of discovery of the death; under these circumstances the provider of services where the incident or occurrence happened is responsible for reporting the death to the Justice Center (as applicable) and/or to OPWDD.

624.5(f) Reporting to OPWDD - Required Reporting Formats.

(1) Reporting using the OPWDD Incident Report and Management Application (IRMA; see glossary, section 624.20).

(i) Information must be entered into IRMA for the following:

*(a)* reportable incidents; and

*(b)* serious notable occurrences

(ii) Reporting initial information in IRMA.

*(a)* 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.

*(b)* When a report of a reportable incident or a serious notable occurrence is made to the VPCR:

(1) initial information is automatically entered into IRMA; however,

(2) agencies are 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.

*(c)* When a report of a reportable incident or a serious notable occurrence is not made to the VPCR, the agency must enter initial information into IRMA within 24 hours of occurrence or discovery or by close of the next working day, whichever is later.

(iii) Reporting subsequent information in IRMA.

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

*(b)* Subsequent information must be entered by the close of the fifth working day after the action is taken or the information becomes available, except as follows:

(1) Information about immediate protections must be entered into IRMA within 24 hours after the action is taken or by the close of the next working day, whichever is later.

(2) A report of death must be entered in IRMA within five working days of the discovery of the death.

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

(i) reporting updates (see subdivision (m) of this section);

(ii) notification of law enforcement officials (see section 624.6); and

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

(4) Agencies are not required to enter information about investigatory activities into IRMA until the investigative report is completed.

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

*(d)* Agencies are required to comply with all requests by OPWDD for the entry of specific subsequent information.

(2) Initial incident/occurrence report.

(i) Minor notable occurrences. Agencies 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, the agency shall either:

*(a)* complete a written initial incident/occurrence report in the form and format specified by OPWDD; or

*(b)* enter initial information into IRMA.

(ii) To comply with any requirement that the agency send or disclose a copy of the initial incident/occurrence report (e.g. in section 624.6 of this Part), the agency must send or disclose either:

*(a)* a copy of the written initial incident/occurrence report completed by the agency pursuant to this paragraph (if one was completed; with redaction if required); or

*(b)* an initial incident/occurrence report printed from IRMA (with redaction if required)

624.5(g) Immediate protections.

(1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must 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.

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

(3) When appropriate, an individual receiving services must 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.

(4) If a person is physically injured, an appropriate medical examination of the injured person must be obtained. The name of the examiner must be recorded and his or her written findings must be retained.

Commentary:

- In accordance with regulation, OPWDD requires providers of services to notify local law enforcement of all reports of physical and sexual abuse (OPWDD Memorandum-Incident Management Updates, January 12, 2015) and all abuse/neglect related to death. Local law enforcement must also be notified of all other possible crimes against an individual by a custodian.

- For all reports of physical and sexual abuse, OPWDD considers it always appropriate to remove target staff from contact with all individuals receiving services during the investigation, unless otherwise approved by OPWDD. Each agency must determine how to comply with this requirement. Staff may be placed on paid or unpaid leave or may be assigned to other duties in which they have no contact with individuals receiving services. Agencies may determine removal of target staff is appropriate to protect individuals receiving services for additional incidents.

624.5(h) General investigation requirements.

(1) Any report of a reportable incident or notable occurrence (both serious and minor) must be thoroughly investigated by the chief executive officer or an investigator designated bythe 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 the agency of the obligation to investigate (see subdivision (i) of this section).

Commentary:

- The chief executive officer may also include a designee, who must be a senior staff person. This designee may assign an investigator acting as the chief executive officer's designee.
- The designee of the chief executive officer should be identified in writing, at least by position,in agency policy/procedure or some other form of information-sharing accessible to staff, persons receiving services, family care providers, family, guardians, correspondents, advocates, service coordinators (case managers), volunteers, interns, etc.
- The definition of investigator (below) in the 624.20 Glossary is:

  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 orthe Justice Center.
- OPWDD requires the following:

  The agency must ensure that the investigator receives the necessary training on the process of conducting a thorough investigation and on the requirements of completing an investigative report in the OPWDD system. The agency is responsible to:

  - ensure every investigator completes training on conducting investigations offered by at least one of the entities listed below (an exception to these entities is also provided below) prior to being assigned any investigation,
    - OPWDD,
    - The Justice Center,
    - InterAgency Council of Developmental Disabilities Agencies, or
    - Labor Relations Alternatives.
    - Any entity may submit an investigative training curriculum to OPWDD for approval. If OPWDD approves the curriculum, the training may be provided in lieu of the trainings above.
  - maintain documentation of the training received by all investigators.
- If an incident is anonymously brought to the attention of an agency, the agency is obligated to manage the incident in conformance with all of the applicable requirements of Part 624.
- Anytime that a person makes a report of abuse or neglect it is to be taken seriously and investigated to determine if the preponderance of evidence supports that the abuse occurred(substantiated), or if the preponderance of evidence supports that the abuse did not occur (unsubstantiated).

(2) Investigations of all reportable incidents and notable occurrences must be initiated immediately, with further investigation undertaken commensurate with the seriousness and circumstances of the situation.

(i) The agency must commence an investigation immediately even when it anticipates that the Justice Center or Central Office of OPWDD will assume responsibility for the investigation.

(ii) When an agency anticipates that the Justice Center or Central Office of OPWDD will assume responsibility for the investigation, the actions taken by the agency are restricted to:

a. securing and/or documenting (e.g. photographing) the scene as appropriate;

b. collecting and securing physical evidence;

c. taking preliminary statements from witnesses and involved parties to the extent necessary to ensure immediate protective measures can be implemented; and

d. performing other actions as specified by the Justice Center or OPWDD.

(iii) In the event that law enforcement directs that the agency forgo any of the actions specified in subparagraph (i) of this paragraph, the agency must comply with such direction.

(iv) The agency is responsible for monitoring IRMA to ascertain whether the Justice Center, the Central Office of OPWDD, or the agency is responsiblefor the investigation.

(v) If the Justice Center or the Central Office of OPWDD is responsible for the investigation, the agency must fully cooperate with the assigned investigator but must not conduct an independent investigation.

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

(3) When an agency becomes aware of additional information concerning an incident that may warrant its reclassification.

(i) 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 must report the additional information to the VPCR. At its discretion, the VPCR may reclassify the incident based on theadditional information.

(ii) In other cases (e.g., incidents in non-certified programs that are not operated by OPWDD or in programs certified under paragraph 16.03(a)(4) of the Mental Hygiene Law that are not operated by OPWDD), the agency will determine whether the incident is to be reclassified and must report any reclassification inIRMA. (This reclassification is subject to review by OPWDD.)

(iii) In the event that the incident is reclassified, the agency must make all additional reports and notifications required by the reclassification.

5. When an agency is responsible for the investigation, the investigation must be documented. Such documentation must include an investigative report.

(iv) For all reportable incidents and notable occurrences, investigative reports must be in the form and format specified by OPWDD.

(v) For reportable incidents and serious notable occurrences, the full text of the investigative report must be entered/uploaded into IRMA pursuant to subparagraph624.5(f)(1)(iii). (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 make the investigative report available through IRMA.)

(3) The investigation must 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.

(4) An agency must 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.

(5) Restrictions on situations that may compromise the independence of investigators.

(i) 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, initially or while the investigation is underway, must report this information to the agency. The agency must relieve the assigned investigator of the duty to investigate if it is determined that there is a conflict of interest in the assignment.

(ii) 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.

(iii) 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.

(iv) Members of an incident review committee (IRC) must 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 must complywith subparagraph 624.7(f)(7)(ii).

(v) For reportable incidents and serious notable occurrences:

*(a)* The agency must 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. The requirements identified in clauses (*b*) and (*c*) of this subparagraph reflect the minimum expectation regarding independence concerning the investigator's work function.

*(b)* 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.

*(c)* 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.

(6) For reports of abuse or neglect in facilities and programs certified or operated by OPWDD, the agency conducting the investigation must notify each subject of the report that an investigation is being conducted, unless notifying the subject of the report would impede the investigation.

(i) Such notification must be made in the manner specified by the Justice Center.

(ii) Such notification or the reason a notification was not made must be reported to OPWDD in the manner specified by OPWDD.

(7) For reports of abuse or neglect in facilities and programs certified or operated by OPWDD, the agency conducting the investigation must submit a request for a check of the Statewide Central Register of Child Abuse and Maltreatment (SCR) concerning each subject of the report.

(i) Such request must 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.

(ii) As a result of the check, the agency may receive information that one or more indicated reports exist concerning the subject of the report. If this occurs, the agency must take appropriate steps to gather information contained in the report as specified by the Justice Center.

(iii) Information obtained pursuant to this paragraph must be included in the investigation records submitted to OPWDD in accordance with subdivision (p) of this section.

624.5(i) Review/investigation by OPWDD and the Justice Center.

(1) 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 must 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.

(2) When an incident or occurrence is investigated or reviewed by OPWDD and OPWDD makes recommendations to the agency concerning any matter related to the incident or occurrence (except during survey activities), the agency must either:

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

(ii) 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.

(3) 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 in subdivision (h) of this section. Note that when the Justice Center conducts the investigation, the Justice Center is not required to adhere to the requirements of such subdivision (h).

624.5(j) Findings of reports of abuse or neglect.

(1) For every report of abuse or neglect, a finding must be made. The agency is required to 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 will make the finding. A finding must be based on a preponderance of the evidence and indicate whether:

(i) 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

(ii) 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.

(2) Concurrent finding. In conjunction with the possible findings identified in paragraph (1) of this subdivision, a concurrent finding may be made that a systemic problem caused or contributed to the occurrence of the incident.

(3) Justice Center review of 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.

Commentary:

- For all incidents of reportable abuse and neglect under the jurisdiction of the Justice Center, regardless of the delegation of the investigation, the Justice Center's findings are considered the final findings. If the Justice Center amends the agency's findings the agency must update information in IRMA to reflect the final findings by the Justice Center

624.5(k) Plans for prevention and remediation for substantiated reports of abuse or neglect when the investigation is conducted by the agency or OPWDD.

(1) Within 10 days of the IRC review of a completed investigation, the agency must 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.

(2) The plan must include written endorsement by the CEO or designee.

(3) The plan must identify projected implementation dates and specify by title agency staff who are responsible for monitoring the implementation of each remedial action identified and for assessing the efficacy of the remedial action.

(4) Such plan must be entered into IRMA by the close of the fifth working day after the development of the plan (see subparagraph 624.5(f)(1)(iii)).

(5) OPWDD will inform the Justice Center about plans developed pursuant to this subdivision.

624.5(l) 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 agency must:

(1) 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

(2) 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.

624.5(m) Reporting updates.

(1) For reportable incidents and serious notable occurrences, an agency must 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, except as noted in paragraph (5) of this subdivision.

(2) The agency must complete required fields in IRMA for the reporting update. Among other required information, the reporting update must include:

(i) 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

(ii) 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.

(3) If the agency is not responsible for conducting the investigation, the agency must complete the required fields to the extent possible given information provided to the agency.

(4) If the agency is responsible for conducting the investigation and if the investigation has not been completed within the timeframe specified in subdivision (n) of this section, the agency must inform OPWDD of the reason for extending the timeframe of the investigation and continue to keep OPWDD informed on at least a monthly basis of the progress of the investigation and other actions taken.

(5) For reportable incidents of abuse and neglect in facilities and programs that are certified or operated by OPWDD, an agency may enter reporting updates into IRMA less frequently than on a monthly basis, if closure of the incident is exclusively pending receipt of written notice from the Justice Center in accordance with subdivision (o) of this section, and:

(i) an initial update is entered into IRMA to document that closure of the incident is pending receipt of such written notice from the Justice Center;

(ii) an update is entered into IRMA by the close of the fifth working day after the agency receives the written notice; and

(iii) no additional updates are requested by OPWDD.

624.5(n) Timeframe for completion of the investigation.
When the agency is responsible for the investigation of an incident or notable occurrence:

(1) The investigation must 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 is considered complete upon completion of the investigative report.

(2) The agency may extend the timeframe for completion of a specific investigation beyond 30 days if there is adequate justification to do so. The agency must document its justification for the extension. Circumstances that may justify an extension include (but are not limited to):

(i) whether a related investigation is being conducted by an outside entity (e.g., law enforcement) that has requested the agency to delay necessary investigatory actions; and

(ii) whether there are delays in obtaining necessary evidence that are beyond the control of the agency (e.g., an essential witness is temporarily unavailable to be interviewed and/or provide a written statement).

624.5(o) Closure of an incident or occurrence.
An incident or occurrence is considered closed:

(1) for reportable incidents of abuse and neglect in programs that are not certified or operated by OPWDD, or are certified under paragraph 16.03(a)(4) of the Mental Hygiene Law and not operated by OPWDD, and for reportable significant incidents and notable occurrences in all facilities and programs certified, operated, or funded by OPWDD:

(i) if the agency conducts the investigation, when the IRC has ascertained that no further investigation is necessary; or

(ii) 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

(2) for reportable incidents of abuse and neglect in facilities and programs that are certified or operated by OPWDD:

(i) 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

(ii) 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

(iii) if the Justice Center conducts the investigation, when the Justice Center provides written notice to the agency that the investigation is completed.

624.5(p) Submission of investigative records.

If an agency conducts the investigation of a report of abuse or neglect or the death of an individual that occurred under the auspices of an agency, the agency must submit the entirety of the investigative record to the Justice Center and/or OPWDD, within 50 days of the VPCR and/or OPWDD accepting such report, as follows:

(1) For reports of abuse or neglect that were reported to the Justice Center, the agency must enter the entirety of the investigative record in the Justice Center's Web Submission of Investigation Report (WSIR) application; or

(2) Effective January 1, 2016, for reports of abuse and neglect that are not required to be reported to the Justice Center and for the death of any individual that occurs under the auspices of an agency, the agency must enter/upload the entirety of the investigative record in IRMA.

(3) Notwithstanding the timeframe specified in this subdivision, the agency may take additional time to submit the investigative record provided, however, that the reasons for any delay must be for good cause and must be documented. The record must be submitted as soon thereafter as practicably possible.

(4) Notwithstanding the requirements in paragraphs (1) – (3) of this subdivision, in the event that the Justice Center or OPWDD conducts the investigation instead of the agency, the agency is not required to submit the investigative record to the Justice Center and/or OPWDD. In the event that OPWDD conducts the investigation, OPWDD will submit the investigative record to the Justice Center. However, agencies must provide information as requested by the Justice Center and/or OPWDD that may be deemed necessary to complete the record.

624.5(q) 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 must provide such requested information in a timely manner.

624.5(r) Duty to report events or situations under the auspices of another agency.

(1) If a reportable incident or notable occurrence is alleged to have occurred while a person was under the auspices of another agency (e.g., day habilitation staff allege that a situation occurred at a residence), the discovering agency must document the situation and must report the situation to the agency under whose auspices the event or situation occurred.

Commentary:

- While it is not necessary to document situations (that meet the definition of a reportable incident or serious notable occurrence) that occur at another agency in IRMA, the agency must keep a record of the event as well as document the manner in which the agency where the event or situation occurred was notified.

- When necessary, agencies and programs must work cooperatively to determine facts of the reported incident. For example: One program discovers and reports an injury, but the time and place it was sustained is not immediately known. The program seeks and should be provided assistance from other programs/providers to determine when and where the injury occurred.

- The agency under whose auspices an incident is reported to have occurred has the responsibility for notifying the OPWDD Incident Management Unit and the Justice Center (where applicable).

(2) Note that mandated reporters (e.g., custodians) are required to make reports to the VPCR pursuant to section 491 of the social services law. 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 which is certified or operated by OWPDD.

(3) It is 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 this Part and agency policy.

(4) If the agency suspecting or alleging the incident or occurrence is not satisfied that the situation will be or is being investigated or handled appropriately, it must bring the situation to the attention of OPWDD.

624.5(s) Records and statistics.

(1) Record retention. Agencies must retain records pertaining to incidents and occurrences as follows:

(i) 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 Part, and documentation regarding compliance with the requirements of this Part.

(ii) Records must be retained for a minimum period of seven years from the date that the incident or occurrence is closed (see subdivision (o) of this section). However, when there is a pending audit or litigation concerning an incident or occurrence, agencies must retain the pertinent records during the pendency of the audit or litigation.

(2) Records, reports, and documentation must be retrievable by the person's name and filing number or identification code assigned by the agency. For incidents and occurrences that are reported in IRMA, such information must be retrievable by the master incident number in IRMA.

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

(i) From a statistical point of view, the situation is considered as one event and must be recorded as such.

(ii) The agency must 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.

624.5(t) Confidentiality of records.

All records generated in accordance with the requirements of this Part must be kept confidential and must 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.

624.5(u) Retaliation.

(1) An agency must 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 the employee or agent makes a report to the VPCR and/or OPWDD in accordance with this section and/or if the employee or agent cooperates with the investigation of a report made to the VPCR or OPWDD.

(2) Effective January 1, 2014, when an agency 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 must include a provision concerning retaliation by the contractor. The provision must require the contractor not to take any retaliatory action against an employee or agent of the contractor when:

(i) the employee or agent believes that he or she has reasonable cause to suspect a person receiving services has been subjected to a reportable incident or notable occurrence, and the employee or agent makes a report to the VPCR and/or OPWDD in accordance with this section; and/or

(ii) if the employee or agent of the contractor cooperates with the investigation of a report to the VPCR and/or OPWDD.

624.5(v) 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 notice is an employee or agent of a contractor, the agency must notify OPWDD of these circumstances within two weeks of such notice in the manner specified by OPWDD.

624.5(w) Dedicated Mailbox for Incident Notifications.

Effective January 1, 2016, every agency providing services that are operated, certified, or funded by OPWDD must establish a dedicated electronic mailbox to receive incident notifications in order to act on issues, including requests from OPWDD, in a timely manner.

Commentary:

- OPWDD sends correspondence to the agency's dedicated mailbox related to incident management and other matters under its jurisdiction as deemed appropriate by OPWDD. It is OPWDD's expectation that the dedicated mailbox is a centralized and functioning agency email address, that may be accessed and is actively monitored on a routine basis by more than one agency staff.

- Agencies are responsible to ensure that the dedicated mailbox email address is operational and that there are effective processes/procedures to ensure that correspondence received from OPWDD is distributed to the appropriate parties within the agency without delay.

- Agencies should promptly contact their respective Incident Compliance Officer within OPWDD's Incident Management Unit when the agency's dedicated mailbox email address is changed.

624.6. Notifications.

(a) 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 must send the written initial incident/occurrence report to the Mental Hygiene Legal Service (MHLS; see glossary, section 624.20) within three working days of occurrence or discovery. The responsible agency or program must also inform MHLS of the results of the investigation.

(b) For reports of abuse or neglect that occur when a person receiving services is under the auspices of a residential facility operated by OPWDD, a family care home sponsored by OPWDD, or a certified day program operated by OPWDD, OPWDD must send the written initial incident report to the appropriate board of visitors within three working days of occurrence or discovery. OPWDD must also inform the board of visitors of the results of the investigation.

(c) 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. In New York City, the police must also be notified.

624.6(d) Reporting to law enforcement.

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

(2) Agencies must 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).

(i) The report to the appropriate law enforcement official must be made as soon as practicable, but in no event later than 24 hours after occurrence or discovery.

(ii) Information about the report to the appropriate law enforcement official must be entered into IRMA within 24 hours of the report being made.

Commentary:

- OPWDD requires providers of services to notify local law enforcement of all reports of physical and sexual abuse (OPWDD Memorandum-Incident Management Updates, January 12, 2015) and all abuse/neglect related to death. Local law enforcement must also be notified of all other possible crimes against an individual by a custodian.

624.6(e) In a case where a subject (see glossary, section 624.20) 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.

**624.6** (f) For all reportable incidents and notable occurrences:

(1) The agency must provide telephone notice to one of the following: a person's guardian, parent, spouse, adult child, or adult sibling.

(2) However, the agency must not provide such notice to a party in the following situations:

(i) if the guardian, parent, spouse, adult child, or adult sibling is the alleged abuser;

(ii) if there is written advice from the guardian, parent, spouse, adult child, or adult sibling that he or she objects to receiving such notification. The notice must then be provided to another party who is a guardian, parent, spouse, adult child, or adult sibling if one exists; or

(iii) 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 (guardian, parent, spouse, adult child, or adult sibling), the capable adult must be provided the notice described in this subdivision.

(3) The telephone notice must 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 the agency.

(4) The telephone notice must include:

(i) a description of the event or situation and a description of initial actions taken to address the incident or occurrence, if any;

(ii) an offer to meet with the chief executive officer (or designee) to further discuss the incident or occurrence; and

(iii) 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 must protect the privacy rights of other parties.

(5) Methods of notification.

(i) The complete telephone notice may include more than one call if 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 must be made within a reasonable timeframe after the initial call.

(ii) Notice may be provided in person rather than by telephone.

(iii) Notice may be provided by other methods at the request of the party receiving the notice.

(6) If the person does not have a guardian, parent, spouse, adult child, or adult sibling or if such parties are not reasonably available, or if there is written advice that such parties do not want to be notified; the agency must provide notice to the following parties in the manner (and subject to the same limitations) specified in this subdivision:

(i) the person receiving services if the person is a capable adult; and

(ii) the person's advocate or correspondent (if one exists).

(7) Requests for the initial incident/occurrence report.

(i) Process for requests.

(a) Requests may be made for a copy of the initial incident/occurrence report by the person receiving services (or who formerly received services), guardian, parent(s), or correspondent/advocate.

(b) Such request must be in writing. However, at the discretion of the agency, a documented verbal request may be accepted in lieu of a written request.

(c) If the person is a capable adult and objects to the provision of the initial incident/occurrence report, such report must not be provided to otherwise eligible requestors.

(d) If an otherwise eligible requestor is the alleged abuser, the written initial incident/occurrence report must not be provided to that requestor.

(ii) Redaction

(a) The copy of the report must 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 may 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.

(b) 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 must be redacted.

(iii) The copy of the initial incident/occurrence report must be provided to an eligible requestor as soon as reasonable, but in no event more than 10 days after the request is made.

(iv) The copy of the initial incident/occurrence report must be accompanied by a statement that all contents are preliminary and have not been substantiated.

(8) Report on actions taken.

(i) The agency must provide a report on initial actions taken to address the incident or notable occurrence. Such report must include:

(a) any immediate steps taken in response to the incident or occurrence to safeguard the health or safety of the person receiving services; and

(b) a general description of any initial medical or dental treatment or counseling provided to the person in response to the incident or occurrence.

(ii) The agency must provide the report on actions taken to any party specified in paragraph (1) or (6) of this subdivision who received the notification.

(iii) The report must be provided within 10 days of the completion of the initial incident/occurrence report (for minor notable occurrences) or entry of initial information in IRMA by the agency.

(iv) The report that is provided must be in the form and format specified by OPWDD or in a similar format developed by the agency

(v) The report that is provided must 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 must be excluded or redacted.

(9) The following documentation must be maintained:

(i) 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;

(ii) any requests for a meeting or the initial incident/occurrence report;

(iii) meetings held in response to the request, and those present;

(iv) when the report on actions taken and any requested written initial incident/occurrence report was provided;

(v) a copy of the report on actions taken and any initial incident/occurrence report (with redaction) that was provided; and

(vi) 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.

(10) For the purpose of redaction as specified in this subdivision and section 624.8 of this Part only, the term employee means any party who is, or formerly was:

(i) directly employed by an agency; or

(ii) 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 include, but are not 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

(iii) a family care provider or family care substitute/respite provider; or a party living in the home of the provider

624.6(g) For the Willowbrook class, agencies must comply with the incident reporting requirements of the Willowbrook Permanent Injunction, dated March 11, 1993.

Commentary:

See *Guidelines for Willowbrook Incident Reporting* (Appendix 4)

624.6(h) The individual's service coordinator (e.g. a Medicaid Service Coordinator or Plan of Care Support Services Service Coordinator, or Willowbrook Service Coordinator) must be notified by the agency 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:

(1) The service coordinator must be notified within 24 hours of the completion of the initial incident/occurrence report (for minor notable occurrences) or entry of initial information in IRMA. The notification must include a description of immediate protections.

(2) 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:

(i) 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 agency employees, consultants, contractors, volunteers, or other individuals receiving services. This information must be provided to the service coordinator within:

*(a)* 10 days after completion of the investigation if the investigation was completed by the agency; or

*(b)* 10 days after the agency receives notice of the results of an investigation conducted by the Central Office of OPWDD or the Justice Center.

(ii) 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 after committee review.

(iii) 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.

(iv) 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 an agency receives a request for this information from a service coordinator, the agency shall provide information that it deems appropriate. In providing this information, the agency must exclude information that directly or indirectly identifies agency employees, consultants, contractors, volunteers, and other individuals receiving services. If an agency determines that it would be inappropriate to disclose specific information requested, the agency must advise the service coordinator of this determination and its justification, in writing, within 10 days after the request. If the agency 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.

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

(3) 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, the agency must not provide information to that party. In such a case, notifications and written information identified in paragraphs (1) and (2) of this subdivision must be provided to the service coordinator's supervisor or the administrator of the agency providing service coordination in lieu of the service coordinator.

624.5(i) 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 must be provided to the QIDP and WCSC in the same manner that the information is provided to the Non-ICF service coordinator, in accordance with paragraphs 624.6(h)(1) and (2). 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 the administrator of the agency providing the 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 the Social Services Law.

624.6(j) Administrative appeal process - denial of requested records/documents.

(1) 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.

(2) 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.

(3) 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, the agency must provide the requested records and/or documents to the requestor.

624.6(k) 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.

624.6(l) Notwithstanding any other provision in this Part, reports of *Obstruction of reports of reportable incidents* (see paragraph 624.3(b)(6)) that are reported to the Justice Center and/or OPWDD are not subject to the notification requirements in this section.

624.7. Incident Review Committee (IRC).

624.7(a) Every agency must have one or more incident review committees 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 will determine the number of committees needed.

Commentary:

- The number of incident review committees is to be determined by the agency. An agency might have a committee for day programs and another for residential programs; or it might have one committee for all.

- An agency might have a committee for its certified facilities and another for non-certified services; or it might have one committee for all.

- The structure and responsibilities of the committee should be in writing.

624.7(b) An IRC must review reportable incidents and notable occurrences to:

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

Commentary:

- Members or a member of the committee should not routinely (regularly) conduct or participate in investigations within the agency (see Section 624.7(c)(4)).

- If a member of the committee conducts an investigation, he or she should not take any role in the committee's review and evaluation of the incident and its investigation. That person could, however, participate in making recommendations (see paragraphs 624.7(c)(5) and 624.7(c)(6)) and other functions of the committee.

- It is the responsibility of the agency's/facility's management and governing body to ensure an environment where committee recommendations are: positively received, carefully considered, and acted upon in the interest of minimizing future occurrences of incidents.

- The committee is also required to review all reportable incidents and notable occurrences involving persons receiving non-certified services under the auspices of the agency

- It is the responsibility of the agency's administration and governing body to ensure that there is a management system for the overall coordination and timely processing of reportable incidents and serious notable occurrences; and that this system is used, in its entirety, for each reported event related to persons receiving services required to be reported under Part 624.

(2) 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 chief executive officer to correct, improve, or eliminate inconsistencies;

Commentary:

- Committee members should be familiar with the expectations of the agency, its incident management system, and its policies/procedures to ensure that appropriate measures are taken and/or have been followed.

- The committee has a responsibility to make recommendations to the chief executive officer or his or her designee.

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

Commentary:

- While the committee may be of the opinion that continued investigation is necessary, it is not its role to conduct such investigations (see Sections 624.7(c)(4) and 624.7(d)).

- The committee may request that further investigative tasks be completed if the agency conducted the investigation.

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

Commentary:

- The Committee may delegate this responsibility to a sub-committee of its membership.

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

Commentary:

- The incident management system developed by the agency's administration, and approved by the governing body, must address the means through which the recommendations will be received and considered in the interest of minimizing future occurrences of incidents.

- The committee is to make recommendations to improve the protection of persons receiving services based on its monitoring of the reporting process for reportable incidents and serious notable occurrences; to evaluate the quality of completed investigations; and to ensure implementation of all recommended corrective action(s).

- The committee should make written recommendations to the chief executive officer, or designee, as to ways to improve, streamline, make more effective, etc., the incident reporting process.

624.7(c) An IRC must:

(1) 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 should 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;

Commentary:

- Depending on the size of the agency, the number of its facilities, the services provided, and the characteristics of its population, monthly meetings may be excessive. Therefore, the regulations allow an agency to determine how frequently the committee must meet, but this can be no less than quarterly. However, the committee is mandated to meet within one month of the date that a reportable incident or serious notable occurrence is discovered and reported.

(2) review and monitor all minor notable occurrences that are reported, which may be done by a sub-committee of the IRC or by 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;

Commentary:

- It is the responsibility of the committee to oversee the process for minor notable occurrences. However, this can be done in the manner deemed most appropriate by the agency. It is acceptable for various members of the committee to be assigned to review minor notable occurrences as a small group (sub-committee of the incident review committee) or even as individuals; there is nothing, however, to preclude the review being done by the entire committee.

- Regardless of the manner in which the review is accomplished, there should be a record of the review, any recommendations made or the actions taken.

- The full committee is to be made aware of the activities/findings of those who handle minor notable occurrences if the review and monitoring is not done by the committee as a whole.

- Statistics should be maintained on all minor notable occurrences, which can then be used to develop trend information.

(3) review and monitor all reportable incidents and/or serious notable occurrences that are reported;

Commentary:

- Reviewing and monitoring do not mean the same as "investigation." The committee is not to investigate incidents.

- The primary focus of the committee is to review reportable incidents and serious notable occurrences to make sure appropriate protections were implemented, the investigation was thorough if investigated by the agency, the classification, corrective actions and recommendations were appropriate and that all other requirements of Part 624 were met.

- Committee members should be familiar with the expectations of the agency, its incident management system and its policies/procedures to ensure that appropriate measures are taken and/or have been followed.

(4) review and monitor investigatory procedures, but shall not perform the routine investigation of reportable incidents or notable occurrences;

Commentary:

- The committee is to critically assess whether or not appropriate investigatory procedures are followed when the investigation is completed by the agency.

- The committee is to make recommendations to the chief executive officer, or designee, when necessary (see paragraph 624.7(c)(6)).

- Members or a member of the committee should not routinely (regularly) conduct or participate in investigations at the agency.

- If a member conducts an investigation, he or she should not be involved in the committee's review and evaluation of the incident and its investigation and is responsible for voluntarily withdrawing from deliberations. That person could, however, participate in making recommendations and other functions of the committee.

- When the investigation is completed by the agency the committee must ensure that the investigator has reviewed all appropriate documentation, interviewed all pertinent witnesses and thoroughly examined all evidence.

- When the investigation is completed by the agency the committee must make sure the investigation identified contributing factors and the cause(s) of the incident so that they can make appropriate recommendations to address the current incident and to help prevent similar incidents from occurring in the future. If the committee finds that the investigation is inadequate the committee should request that the investigation be re-opened. The incident should remain open until an acceptable investigation is completed.

- It is recommended that committee members receive investigation training.

(5) 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;

Commentary:

- The agency, with the oversight of the governing body, must ensure that there is a process for the committee's written recommendations to be sent to appropriate staff and administrators so as to foster an environment whereby such recommendations are positively received, considered, and responded to.

- It is the related responsibility of the agency's administration and governing body to create an environment whereby committee recommendations are positively received and considered in the interest of minimizing future occurrences of incidents and responded to, by the designated administrator in writing.

- It is the responsibility of the agency's administration and the governing body to ensure and enforce an agency procedure which provides for a written response to the committee, by staff receiving recommendations.

(6) 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;

Commentary:

- The committee has an advisory responsibility to the chief executive officer and other administrative staff he or she designates.

- It is the responsibility of the agency's administration and governing body to foster an environment where committee recommendations are positively received and considered in the interest of minimizing future occurrences of incidents.

(7) forward findings and recommendations to the chief executive officer within two weeks of meeting;

Commentary:

- The manner in which such information is forwarded to the chief executive officer, or designee, and other staff is to be determined by the agency.

(8) 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;

Commentary:

- The agency determines how such documentation will be made. Inclusion in the committee minutes would be sufficient to document that such recommendations have been forwarded.

- The confidentiality of those whose names appear in the minutes needs to be considered.

- The agency staff shall establish a standardized procedure and written format for the regular transmittal of the standing committee minutes and recommendations to the appropriate agency executives.

(9) monitor actions taken on any and all recommendations made and advise the chief executive officer when there is a problem;

Commentary:

- If there is a lack of action taken, without justification, the chief executive officer, or designee, needs to be made aware of the situation.

- It is the responsibility of the chief executive officer and the governing body to ensure that committee recommendations are positively received and considered in the interest of preventing future occurrences of incidents and abuse.

(10) 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 (see subdivision 624.2(e)). This may be done by the full committee or a member of a subcommittee reporting to the full committee;

Commentary:

- While the committee or sub-committee may do trend analysis of other events (e.g., *agency reportable incidents* or other situations that are potentially dangerous to persons receiving services), it is not necessarily the role of the committee to do this. Trend analysis may be done elsewhere within the agency.

(11) in accordance with agency policy, report periodically, but at least annually, to the chief executive officer, chief agency executives, the governing body, and OPWDD concerning the committee's general monitoring functions; general identified trends in reportable incidents and notable occurrences; and corrective, preventive, remedial and/or disciplinary action pertaining to identified trends; and

Commentary:

- The committee may prepare a single report summarizing the activities over the course of the past year which may serve all parties identified in the regulation; they may report monthly or quarterly; or they may report to any frequency as long as it is no less than annually.

- The emphasis of the report is to be on the general activities/functioning of the committee. Hence, information included in the report should include aggregated data and/or information and not individual case specifics.

- The report should include, at a minimum, the general identified trends in reportable incidents and notable occurrences for the time period which the report covers; an analysis of the trends identified; and a summary of the types of corrective action(s) which have been developed, taken by the agency, in an effort to avoid circumstances known to have resulted in reportable incidents and notable occurrences.

(12) interact with the governing body and comply with the policies in relation to the review and monitoring of all reportable incidents and notable occurrences.

Commentary:

- The governing body is to be available to the committee for support and guidance.
- The agency's incident management system, as reflected in agency policy, the minutes of the committee; the committee's annual report, and, where appropriate, minutes of the governing body may provide substantiation of compliance with this requirement.

624.7(d) For reportable incidents of abuse and neglect in facilities and programs that are certified or operated by OPWDD, an incident will 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.

Note: The Justice Center may amend findings made by an agency or OPWDD. Findings made by the Justice Center are considered final.

Commentary:

- For all incidents of reportable abuse and neglect under the jurisdiction of the Justice Center, regardless of the delegation of the investigation, the Justice Center's findings in the Letter of Determination are considered the final findings. If the Justice Center amends the agency's findings the agency must update information in IRMA to reflect the final findings by the Justice Center.

624.7(e) Role of the IRC when investigations are conducted by the Central Office of OPWDD or the Justice Center. Notwithstanding any other provision of this Part, when an investigation of an incident or occurrence is conducted by the Central Office of OPWDD or the Justice Center:

(1) The IRC role in reviewing and monitoring the particular incident or occurrence is limited to matters involving compliance with the reporting and notification requirements of this Part, protective and remedial actions taken (except disciplinary actions concerning services operated by OPWDD), operational concerns, and the quality of services provided.

(2) The finding (of the report of abuse or neglect) of substantiated or unsubstantiated must be made by the Central Office of OPWDD or the Justice Center.

(3) Concerning services operated by OPWDD:

(i) The IRC must monitor all actions taken to implement recommendations made by the Central Office of OPWDD or the Justice Center, except recommendations for disciplinary action.

(ii) The IRC for state-operated services must not review or monitor disciplinary action recommendations made by the Central Office of OPWDD or the Justice Center.

(4) Concerning facilities and programs that are not operated by OPWDD, including non-certified programs and programs certified under paragraph 16.03(a)(4) of the Mental Hygiene Law, the IRC must monitor all actions taken to implement recommendations made by the Central Office of OPWDD or the Justice Center.

624.7(f) Organization and membership of the IRC.

(1) A committee or committees may be established to meet the organizational needs of an agency (e.g., on an agency-wide basis, for a certified class of facilities, for a grouping of certified classes of facilities, by types of services provided, etc.). An agency may establish its own committee or committees and/or may meet the requirements of this section in several other ways, either concerning all operations of the committee or for specific incidents/occurrences or types of incidents/occurrences.

(i) An agency may coordinate with other agencies in the establishment of a shared committee.

(ii) An agency may also coordinate with a different agency to use the other agency's IRC.

(iii) An alternate acceptable committee review arrangement may be established with the approval of OPWDD.

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

(3) An IRC may have other responsibilities in addition to specified responsibilities related to reportable incidents and notable occurrences.

(4) Membership of an IRC must include:

(i) except for state-operated services, a member of the governing body;

(ii) for state-operated services, a high-level administrator (note: this cannot be the Director);

(iii) at least two professional staff, including but not limited to, licensed clinicians, such as occupational, physical, and speech therapists, social workers, psychologists, and nurses; a behavioral intervention specialist (BIS, see subdivision 633.16(b) ); and others with primary responsibility for developing and/or monitoring individuals' plans of care, such as developmental and habilitation specialists or a QIDP. At least one of the professional staff must be a licensed health care practitioner (e.g. physician, physician's assistant, nurse practitioner, or registered nurse).

(iv) other staff, including administrative staff, as deemed necessary by the agency to achieve the purposes of the committee pursuant to this section;

(v) at least one direct support professional (except for agencies that do not have direct support professionals);

(vi) at least one individual receiving services;

(vii) at least one representative of advocacy organizations (e.g. self-advocacy, family, or other advocacy organizations); and

(viii) the participation of a psychologist on the committee is recommended.

(5) In the event that an agency is unable to obtain the members required by subparagraphs (i) and (v) – (viii), the agency must document its periodic efforts to obtain the specified members.

(6) Membership limitations.

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

(ii) 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.

(7) Case-specific requirements.

(i) There must be representation by someone from or with knowledge of the program or service within the agency where the event under discussion occurred, or by someone who is familiar with the person(s) involved.

(ii) Restrictions on review of specific incidents or allegations of abuse.

*(a)* Any committee member who recognizes a potential conflict of interest in his or her assignment must report this information to the committee and recuse him or herself from participating in committee review of the incident or occurrence in question.

*(b)* 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.

*(c)* 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.

*(d)* 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.

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

624.7(g) Minutes. The chairperson of an incident review committee must ensure that minutes are kept for all meetings.

(1) For reportable incidents and serious notable occurrences, the portion of the minutes that discuss matters concerning the specific event or situation must be entered into IRMA within three weeks of the meeting.

(2) Minutes addressing the review of specific reportable incidents and/or serious notable occurrences must 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 must be recorded (not initials).

624.8. Release of records.

624.8(a) Policies and procedures. Agencies must 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.

Commentary:

- Agency policies and procedures should provide an overview of the process for releasing records and/or documents pertaining to reportable incidents.

- The policies and procedures must address at a minimum which staff are authorized to receive requests for records and documents and those staff who are authorized to release records to eligible requestors.

- Policies and procedures may include topics such as redaction, determination of the validity of a request (not an eligible requestor, not a timely request, not under the auspices of an agency, etc.), timelines or documentation.

- Policies and procedures must be in compliance with all applicable regulations including, but not limited to, "Jonathan's Law" and "HIPAA".

- See *Guidance Documents* (Appendix 5) *Part 624 Jonathan's Law Requirements*.

624.8(b)

Eligible requestors. Persons receiving services or who formerly received services, and guardians, parents, spouses, adult children, and adult siblings 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 as established by this section, subject to the following restrictions:

Commentary:

- The only individuals who are eligible to request records and documents pertaining to an allegation and investigation of reportable incidents are:
  - a person receiving services who is the subject of the reportable incident; and
  - any guardian, parent, spouse, adult child, or adult sibling of the person receiving services who is the subject of the reportable incident (if he or she is a "qualified person" according to paragraph 33.16(a)(6) of the Mental Hygiene Law).
- Legal guardians appointed for children or adults are generally considered "qualified persons." These include (but are not limited to) guardians appointed pursuant to Article 17-A of the Surrogate's Court Procedure Act and Article 81 of the Mental Hygiene Law, and legal guardians for children.
- If the guardianship order limits the authority of the guardian so that the guardian would not have relevant authority (e.g. over property only), the records and documents should not be provided.
- Parents of minors (under the age of 18 years) are considered to be "qualified persons" unless their parental rights have been legally terminated.
- Generally, parents, spouses, adult children, or adult siblings of adults receiving services (age 18 or older) are "qualified persons" if they are involved with the person receiving services and they have consented to service plans and/or medical/dental treatment in the past. If they have not consented in the past but would be asked to provide consent should a need arise at the present, they would also be considered to be "qualified persons."
- A guardian, parent, spouse, adult child, or adult sibling is not eligible to receive documents and records pertaining to reportable incidents when the individual receiving services is not the subject of the report. For example, a person receiving services may be interviewed during the course of an investigation because he or she was a witness. In this case the "interviewee" and the guardian, parent, spouse, adult child, or adult sibling of the person interviewed are not authorized to receive a copy of those records.
- If more than one eligible person requests the investigation records and documents, the documents must be provided to all eligible requestors.
- If the person is 18 years of age or older, is a "capable adult" according to the definition in Section 624.20(c) ("adult, capable"), and objects to the records and/or documents being provided to an otherwise eligible requestor, the agency is to adhere to the wishes of the capable adult. Such capability and objection should be documented.
- When an agency denies a request for record and documents, the agency must inform the requestor in writing of the opportunity to appeal such denial to the OPWDD Incident Records Appeals Officer. The agency shall inform the requestor of the opportunity to send his or her written appeal to the OPWDD Incident Records Appeals Officer, Office of Counsel, 44 Holland Avenue, Albany, NY 12229. The right to appeal a denial is in subdivision 624.8(i).

624.8(b)(1) 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.

Commentary:

- If the guardian, parent, spouse, adult child, or adult sibling is the "target" of a reportable incident, that individual is not eligible to receive records or documents pertaining to that specific report. This is true regardless of the conclusion of the investigation.

- This does not preclude the individual from being provided records and documents pertaining to a different reportable incident in which he or she was not the target.

- This also does not preclude another eligible requestor (who is not the target) from requesting and receiving the records and documents.

- Events and situation reported under Part 625 do not occur under the auspices of the agency, therefore, are not subject to release.

624.8(b)(2) 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.

Commentary:

- If the person is 18 years of age or older, is a "capable adult" according to the definition in Section 624.20(c) ("adult, capable"), and objects to the records and/or documents being provided to an otherwise eligible requestor, the agency is to adhere to the wishes of the capable adult. Such capability and desire should be documented.

- There is no requirement that a capable adult "give permission" for the provision of the records and/or documents to an eligible requestor. Agencies are not specifically required to ask the person receiving services whether they have an objection to the release of records. If agencies have any question whether the person receiving services might object to the provision of the records and documents to the requestor, agencies should ask the person. If a capable adult objects to the provision of such, the documents and/or records shall not be provided to the otherwise eligible requestor.

- The definition of "capable adult" in Section 624.20(c) is: "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's Court Procedure Act." In general, this means that if a request is made by a guardian, and the person receiving services lodges an objection to the provision of records and/or documents, the agency must provide the requested records and/or documents to the guardian. If the guardianship order limits the authority of the guardian so that the guardian would not have relevant authority (e.g. over property only) and the capable adult objects, the records and documents would not be provided.

624.8(c) Records subject to release concerning reports of abuse that occurred prior to June 30, 2013.

(1) 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.

(2) 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.

(3) 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.

624.8(d) 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.

Commentary:

- Employee personnel files or disciplinary procedures are not to be considered part of the investigation documents and records.
- Events and situation reported under Part 625 do not occur under the auspices of the agency, therefore, are not subject to release.
- See Section 624.20(j) for a detailed definition of "auspices, under the."

624.8(e) Procedures. Eligible requestors shall submit a written request to 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 must 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 must provide the requested records no later than 21 days after the request is made. The written request must specify the records that are requested.

Note: The criteria for closure of an incident are in subdivision 624.5(o) of this Part.

624.8(f) Redaction of records.

624.8(f)(1) Prior to the release of records, agencies must 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. For the purpose of this section, "employee" has the same meaning as in section 624.6(f)(10) of this Part. Redaction may be waived if the employee or person authorizes disclosure, unless redaction of the specific information is necessary because it tends to identity another employee or person who has not authorized disclosure or for another reason specified in this subdivision.

Commentary:

- Redaction must be done in the spirit of meaningful disclosure.
- Redaction applies to names and information that would identify or tend to identify, an employee or individual receiving services (i.e. date of birth, employee title, gender or physical attributes).
- Redaction also applies to employees and individuals who complete or review the initial incident report who participate in or conduct the investigation, who are part of the investigation review process, or who are interviewed as part of the investigation.
- Information that provides description, context or follow-up should not be redacted. It would be inappropriate to redact information such as a description of the event, date and time, location, or referrals made.
- The name of the individual receiving services does not have to be redacted if the records and documents are going to be reviewed by that individual's parent, guardian, spouse, adult child, adult sibling or advocate/correspondent. The names and identifying information of all other individuals receiving services should be redacted.
- Agencies should keep the original non-redacted records and documents, as well as a copy of the redacted records and documents which were provided to the requestor.
- The process of redaction will likely involve blacking out the relevant information and then copying the relevant page. The requestor should be provided the copy. Agencies should keep in mind that it is often possible to ascertain information which is blacked out on a document which is not copied.

624.8(f)(2) In addition, if any records that 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 must be redacted.

Commentary:

- The identity of an individual making a report to the Statewide Central Register of Child Abuse and Maltreatment (SCR), contacted the SCR or otherwise cooperated in a child abuse/maltreatment investigation must be redacted, even if the individual authorizes disclosure.

- Redaction only applies to information that would tend to identify an employee or individual receiving services, not information that provides description, context or follow-up.

624.8(g) Cover letter and dissemination restrictions. The release of records to recipients must be in accordance with the following:

(1) The release of records must 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:

(i) a health care provider;

(ii) a behavioral health care provider;

(iii) law enforcement, if you believe a crime has been committed; or

(iv) your attorney."

(2) 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.

Commentary:

- Prepare a cover letter to the qualified party. As per MHL 33.25(c) the cover **must** include the following language:

  "PURSUANT TO SECTION 33.25 OF THE NYS MENTAL HYGIENE LAW, THE ATTACHED RECORDS AND REPORTS SHALL NOT BE FURTHER DISSEMINATED EXCEPT THAT YOU MAY SHARE THE REPORT WITH: (I) A HEALTH CARE PROVIDER; (II) A BEHAVIORAL HEALTH PROVIDER; (III) LAW ENFORCEMENT IF YOU BELIEVE A CRIME HAS BEEN COMMITTED; OR (IV) YOUR ATTORNEY."

- Please see Appendix 9 for sample letters.

624.8(h) Documentation.

(1) The written request for the release of records must be maintained and the time the request was received must be documented.

(2) A copy of the redacted records that were released must be maintained and the time the records were provided must be documented.

Commentary:

- Documentation may be maintained by the agency in whatever manner the agency deems appropriate. However, the agency must be able to produce the documentation upon request.

- Agencies should keep the original non-redacted records and documents, as well as a copy of the redacted records and documents which were provided to the requestor.

624.8(i) Administrative appeal process - denial of requested records/documents.

(1) 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.

(2) 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.

(3) 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 must provide the requested records and/or documents to the requestor.

Commentary:

- See Administrative Appeal Process for Denials of Records Requested Pursuant to the 14 NYCRR Part 624 Incident/Abuse Reporting, Notification and Investigation Process -OMRDD ADM #2009-04, which is Appendix 10 for additional information.

- When an agency denies a request for record and documents, the agency must inform the requestor in writing of the opportunity to appeal such denial to the OPWDD Incident Records Appeals Officer. The agency shall inform the requestor of the opportunity to send his or her written appeal to the OPWDD Incident Records Appeals Officer, Office of Counsel, 44 Holland Avenue, Albany, NY 12229.

- The Incident Records Appeals Officer will render a determination within 20 business days of making the request for information to the agency if the agency does not respond to the Officer's request within 10 business days.

624.8(j) 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.

Commentary:

- Records requests under Social Services Law 496 are to be directed to the NYS Justice Center. These requests cannot be fulfilled by OPWDD or by an OPWDD provider.

- Requests are to be directed to recordsaccessofficer@justicecenter.ny.gov

624.20. Glossary.

(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, prior to May 31, 2014, that in an ICF/DD 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.

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(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 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 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.

(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 may assist a person in obtaining necessary services and participate 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 that:

(1) is attributable to

(i) mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, or autism;

(ii) 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; or

(iii) dyslexia resulting from a disability described in subparagraph (i) or (ii) of this paragraph;

(2) originates before an individual attains age 22;

(3) has continued or can be expected to continue indefinitely; and

(4) constitutes a substantial handicap to an individual'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*. For the purposes of this Part, his term is used in accordance with 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*. For the purposes of this Part, this term is used in accordance with 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 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, 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) *Team, program planning*. Those, by whatever name known, acting as a unit, responsible for identifying an individual's needs; developing, implementing, and evaluating the plan of services for that person; and ensuring that the setting and/or services received are appropriate. Regulations for a specific class of facility are to be referenced for specific details. For those enrolled in the Home and Community-Based waiver (HCBS), the program planning team is defined as the individual and the service coordinator, and the advocate (if appropriate) as well as any other party or parties considered, at any given time, as being appropriate for participation by that group.

(ak) *Treatment, requiring medical or dental*. For the purposes of this Part, a situation in which a person who, by virtue of his or her condition as a result of an injury, 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 an agency's policy and procedures may direct that a person who is in any way injured or has suffered any ill effects is to see a medical professional, even though first-aid has adequately addressed the injury, 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 considered a situation that required medical treatment, and be reported as a serious notable occurrence.

(al) *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.

(am) *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 facilities and 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.

# SECTION III - Link to Article 130 – NY Penal Law

# Article 130 – NY Penal Law

The definition for sexual abuse contains references to the Penal Law. Below is a link to Article 130 of the Penal Law for your convenience.

http://ypdcrime.com/penal.law/article130.htm?zoom_highlight=130

**Article 130 - NY Penal Law**

**SEX OFFENSES**

130.00 Sex offenses; definitions of terms.
130.05 Sex offenses; lack of consent.
130.10 Sex offenses; limitation; defenses.
130.16 Sex offenses; corroboration.
130.20 Sexual misconduct.
130.25 Rape in the third degree.
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130.35 Rape in the first degree.
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130.52 Forcible touching.
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130.65 Sexual abuse in the first degree.
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130.66 Aggravated sexual abuse in the third degree.
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130.75 Course of sexual conduct against a child in the first degree.
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130.85 Female genital mutilation.
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130.91 Sexually motivated felony
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**Link for 255.25, 26 and 27 sections**:

http://ypdcrime.com/penal.law/article255.htm?zoom_highlight=255

255.25 Incest in the third degree.
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**Link for Article 230 – NY Penal Law**:

http://ypdcrime.com/penal.law/article230.htm?zoom_highlight=230

**Article 230 - NY Penal Law**
**PROSTITUTION OFFENSES**

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230.02 Patronizing a prostitute; definitions.
230.03 Prostitution in a school zone. A MISD
230.04 Patronizing a prostitute in the third degree. A MISD
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230.07 Patronizing prostitute; defense.
230.10 Prostitution and patronizing a prostitute; no defense.
230.15 Promoting prostitution; definitions of terms.
230.19 Promoting prostitution in a school zone. E FELONY
230.20 Promoting prostitution in the fourth degree. A MISD
230.25 Promoting prostitution in the third degree. D FELONY
230.30 Promoting prostitution in the second degree. C FELONY
230.32 Promoting prostitution in the first degree. B FELONY
230.33 Compelling prostitution. BFELONY
230.34 Sex Trafficking B FELONY
230.35 Promoting or compelling prostitution; accomplice.
230.36 Sex Trafficking: accomplice
230.40 Permitting prostitution. BMISD

**Link for Article 263 – NY Penal Law**:

http://ypdcrime.com/penal.law/article263.htm?zoom_highlight=263

**Article 263 - NY Penal Law**

**SEXUAL PERFORMANCE BY A CHILD**

263.00 Definitions.
263.05 Use of a child in a sexual performance.
263.10 Promoting an obscene sexual performance by a child.
263.11 Possessing an obscene sexual performance by a child.
263.15 Promoting a sexual performance by a child.
263.16 Possessing a sexual performance by a child.
263.20 Sexual performance by a child; affirmative defenses.
263.25 Proof of age of child.
263.30 Facilitating a sexual performance by a child with a controlled substance or alcohol.

# SECTION IV - OPWDD 147 Form and Instructions

This information can be found at the following link:

http://www.opwdd.ny.gov/opwdd_resources/incident_management/forms

# SECTION V - OPWDD 148 Form

This information can be found at the following link:

http://www.opwdd.ny.gov/opwdd_resources/incident_management/forms

# SECTION VI - Part 625 - Events and Situations

Part 625 Events and Situations that are not under the auspices of an agency

625.1 Applicability.

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

(b) 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 of this Title.)

(c) The requirements of this Part apply to events and situations that occur on or after June 30, 2013.

(d) Intermediate Care Facilities (ICFs, see Part 681 of this Title), including state operated developmental centers, 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 Part 483 that are more stringent than requirements of this Part.

(e) Programs that are certified under paragraph 16.03(a)(4) of the Mental Hygiene Law and are funded by OPWDD, but that are not operated by OPWDD, are required to report and address events and situations that are not under the auspices of an agency in accordance with this Part. Such certified programs are not, however, required to report deaths to the Justice Center.

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.

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

(a) 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 (see subdivision 625.2(a)), the agency must respond to the event or situation as follows:

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

(i) The agency must comply with the requirements of subdivision 624.5(r) of this Title. This includes the requirement to document the event or situation and report the situation to the agency under whose auspices the event or situation occurred.

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

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

(3) The agency must intervene as specified in subdivision (b) of this section 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 section 625.2 of this Part, unless the event or situation meets the criteria in paragraphs (1) or (2) of this subdivision.

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

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

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

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

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

(4) assessing and monitoring the individual;

(5) reviewing records and other relevant documentation; and

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

(c) The agency must intervene as it deems necessary and appropriate (see subdivision (b) of this section for a list of interventions) when the event or situation meets the

definition of physical, sexual, or emotional abuse; active, passive, or self neglect; or financial exploitation, and involves an adult who meets the following criteria:

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

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

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

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

(d) 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:

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

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

(3) the individual is in need of protective services that the agency cannot provide.

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

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

(1) The agency responsible for intervening must 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.

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

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

(a) Reporting to OPWDD. The agency must report events or situations in which actions were taken by the agency in accordance with the requirements of section 625.3 of this Part as follows:

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

(2) The agency or sponsoring agency must 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 must identify all actions taken by the agency, including any initial actions taken to protect the involved individual.

(3) The agency must 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 must include information about subsequent interventions (see subdivision 625.3(b)) and include information about the resolution of the event or situation.

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

(b) Review/investigation by OPWDD.

(1) OPWDD has the right to investigate or review any event or situation regardless of the source of the information. The agency must provide OPWDD reviewers or investigators with all relevant records, reports, and other information pertaining to

the event or situation. Individuals receiving services, staff, and any other relevant parties may be interviewed in pursuit of any such review or investigation.

(2) When an event or situation is investigated or reviewed by OPWDD, OPWDD may make recommendations to 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 must either:

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

(ii) 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.

*625.5* Agency and OPWDD involvement in deaths that are not under the auspices of the agency.

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

(1) The initial report must be submitted, by the agency's chief executive officer or designee, to the Justice Center death reporting line, in a manner specified by the Justice Center.

(2) The death must be reported immediately upon discovery and in no case more than twenty-four hours after discovery.

(3) Subsequent information must be submitted to the Justice Center, by submission of the *Report of Death* in IRMA within five working days of discovery of the death.

(4) The results of an autopsy, if performed and if available to the provider agency, must 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 in this subdivision do not apply to the death of an individual who received only OPWDD funded services (such as community habilitation or supported employment services) provided by a voluntary-operated agency, rather than services that are operated or certified by OPWDD, to the death of an individual who resided in an OPWDD certified or operated residential program (see paragraph 625.2(a)(1) of this Part), or when the death occurred under the auspices of any agency.

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

(1) A death that occurred under the auspices of a provider agency (see paragraph 625.2(a)(1) of this Part) must be reported as a serious notable occurrence in accordance with Part 624 of this Title.

(2) A death that did not occur under the auspices of any agency (see paragraph 625.2(a)(2) of this Part) must be reported in accordance with subdivision (c) of this section.

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

(1) All deaths must 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) is not sufficient to satisfy this requirement.

(2) The agency must 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 by submission of the *Report of Death* in IRMA within five working days following discovery of the death.

(d) If more than one agency provided services to the individual, there must 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:

(1) 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 of service on a regular basis);

(2) MSC or PCSS (only OPWDD operated services report to the Justice Center);

(3) HCBS Waiver services (only OPWDD operated services report to the Justice Center);

(4) Care at Home Waiver services (only OPWDD operated services report to the Justice Center);

(5) Article 16 clinic services;

(6) FSS or ISS services (only OPWDD operated services report to the Justice Center);

(7) Any other service operated or funded by OPWDD.

(e) Investigations into deaths that did not occur under the auspices of an agency.

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

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

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

# APPENDIX 1 - OPWDD Guidelines for the Completion for the Assessment used to determine the effect of Psychological Abuse

## OPWDD Guidelines for the Completion of the Assessment used to determine the effect of Psychological Abuse

A. **Background:** The Protection of People with Special Needs Act (PPSNA) established the Justice Center and reformed policies and procedures concerning incident management effective June 30, 2013. These changes included adding a new definition of "psychological abuse" (see SSL 488(1)(c)). OPWDD amended14 NYCRR paragraph 624.3(b)(3) to add a conforming definition of "psychological abuse" and provided examples of behaviors that might constitute psychological abuse. The regulation also states: "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.***"

In addition to complying with Part 624, Intermediate Care Facilities for Individuals with Developmental Disabilities (ICFs/IID) must also comply with federal regulations in 42 CFR Part 483. In some instances, the federal regulations and guidelines are more stringent than the requirements in Part 624.

B. **Purpose and Applicability:** This guidance is intended to provide clarification to clinicians who conduct the clinical assessment that is required to substantiate a report of psychological abuse.

C. **Applicability in ICFs:** Federal ICF regulation guidelines define "verbal abuse" as any use of oral, written, or gestured language by which abuse occurs. This includes pejorative and derogatory terms to describe persons with disabilities. The guidelines also note that "psychological abuse" includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation, sexual coercion, intimidation, whereby individuals suffer psychological harm or trauma. Such conduct involving a custodian under the auspices of an ICF must be reported to the Justice Center as psychological abuse. However, the Justice Center may not accept or substantiate reports if the conduct did not or is not likely to cause, a "substantial diminution of the emotional, social or behavioral development or condition of the individual receiving services."

The interpretive guidelines for ICF federal regulation 483.420(a)(5) specify that, "Since many individuals residing in ICFs/MR [IID] are unable to communicate feelings of fear, humiliation, etc., the assumption must be made that any actions that would usually be viewed as psychologically or verbally abusive by a member of the general public, is [sic] also viewed as abusive by the individual residing in the ICF/MR [IID], regardless of that individual's perceived ability to comprehend the nature of the incident."

Even though the Justice Center may not accept all ICF reports of psychological abuse or substantiate psychological abuse in the absence of substantial diminution, ICF providers must comply with Part 624 requirements and also with federal regulations and guidance in Part 483.

**D. Definitions for the purpose of these guidelines only:**

(1) ***Clinical assessment***, herein referred to as assessment, means an assessment performed by a clinician to provide evidence of whether the behavior of a custodian has caused, or is likely to cause, a "substantial diminution of the emotional, social or behavioral development or condition of the individual receiving services" over a sufficient period of time. The clinician shall determine the length of time sufficient and necessary to conduct the assessment, including time to monitor the individuals' symptoms or behavior, in order

to determine the effect the custodian's conduct had on the service recipient. The assessment provides evidence of the effect, if any, that the conduct has had on the individual receiving services.

(2) ***Clinician qualified to complete the assessment of substantial diminution*** means a physician (M.D. or D.O.; preferably a psychiatrist), psychologist, psychiatric nurse practitioner, licensed clinical or master social worker (LCSW, LMSW), or licensed mental health counselor (LMHC).

(3) ***Personal Representative***, used within this document, means the following:

(i) For individuals receiving services under the age of 18 is a legal guardian, an actively involved spouse, a parent, an actively involved adult sibling, an actively involved adult family member, or a local commissioner of social services with custody of the person.

(ii) For individuals over the age of 18, the term personal representative shall mean a legal guardian, an actively involved spouse, an actively involved parent, an actively involved adult child, an actively involved adult family member, and the Consumer Advisory Board for Willowbrook Class members who are fully represented.

(4) ***Psychological Abuse*** is defined in 624.3(b)(3) and means "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 an assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor.

**E. Appointing a Clinician to complete the assessment:**

(1) It is the provider agency's responsibility to identify and appoint a clinician within twenty-four hours following the investigator concluding that it reasonably appears that the conduct that was reported as psychological abuse actually occurred (see the section titled "Procedure" within this document).

(2) The clinician must be selected based on his or her ability to provide an informed clinical opinion regarding the effect that a custodian's behavior had on the individual receiving services.

(3) Certain situations may compromise the independence of the clinician assigned to complete the assessment. It is recommended that the restrictions in paragraph 624.5(h)(7) be applied. Agencies should avoid appointing a clinician when:

(i) the clinician, his or her spouse or domestic partner, or immediate family member were allegedly involved in the incident or

(ii) the clinician, his or her spouse or domestic partner, or immediate family member provides supervision to the program where the incident occurred, serves on the agency's executive board or equivalent, or directly supervises an involved party.

(4) The clinician must use professional and clinical judgment to determine whether it is appropriate to assess an individual with whom he or she has an established therapeutic relationship.

(5) The clinician must communicate concerns regarding his or her independence as a clinician performing the assessment to the agency director or equivalent in effort to address and remediate any potential concerns or conflicts.

(6) It is recommended that the clinician complete training on conducting this type of assessment.

## F. The Assessment to Provide Evidence of "Substantial Diminution."

### (1) Purpose of the Assessment

(i) The purpose of this assessment is to provide evidence of whether the behavior of a custodian has caused, or is likely to cause, a "substantial diminution of the emotional, social or behavioral development or condition of the individual receiving services."

(ii) The clinician must examine the effect, if any, that the conduct had on the individual. This involves identifying the individual's emotional, social, and behavioral development or condition prior to the conduct; determining any change in the person's development or condition following the custodian's conduct; and assessing if this change in development or condition is significant and present for a substantial period of time.
Generally speaking, the factors defined in this paragraph should be considered over a two-week (ten day) period; however, the time period (i.e., less than 2 weeks, more than 2 weeks) necessary to fully complete the assessment shall be determined by the clinician as clinically indicated. See section 3 item (vii) of this document for information regarding assessments that may take longer than thirty days to complete. As required in 42 CFR 483.420(d)(4), ICFs are required to submit the results of all investigations to the administrator, or his/her designee, within five days of the incident and nothing in this guidance prohibits the completion of the five day report.

(iii) This assessment to provide evidence of the effect of psychological abuse **is not** a forensic interview. This assessment is not intended to serve as evidence for legal purposes and is not a credibility assessment. Additionally, the assessment to provide evidence of the effect of psychological abuse is not intended to be a diagnostic evaluation.

(iv) The assessment to provide evidence of the effect of psychological abuse is completed for the purposes of an investigation and shall in no way be deemed a substitute for any clinically indicated assessments, evaluations, or interventions necessary to appropriately provide care to the individual. For example, this

clinical assessment cannot be used in place of treatment plans, regular assessments or reports, or capacity assessments. However, findings and recommendations from the assessment may identify treatment needs and may be used for treatment planning for an involved individual.

**(2) Assessment Techniques**

(i) The assessment should be completed using evidence-based techniques and best practices including the techniques identified through the OPWDD approved training on conducting an assessment to provide evidence of the effect of psychological abuse.

(ii) The assessment to provide evidence of the effect of psychological abuse should include the following:

(a) Interview(s) with the individual receiving services regarding the custodian's conduct including his or her awareness that the incident occurred and his or her reaction, if any, to the incident. This should include discussing changes in behavior or symptoms;

(b) A review of relevant clinical records and documentation that will enable the clinician to evaluate and consider the person's history, including any trauma history, as well as assess changes in symptoms or behavior;

(c) Interview(s) with informants such as staff or family members (as deemed appropriate by the clinician) to assess the individual's behavior both before and after the incident;

(d) Behavioral observations;

(e) Identifying appropriate clinical or treatment recommendations.

**(3) Procedure**

(i) Upon learning of an allegation of psychological abuse, the agency should take necessary steps to ensure that the behavior and symptoms demonstrated by the individual(s) allegedly subjected to abuse are monitored and documented in his or her progress notes or through other forms of retrievable documentation such as meal, sleep, mood, behavior, or communication log (s). Information pertaining to the individual's demonstrated behavior and symptoms is observed, monitored, and documented for a period of time that is clinically indicated as determined by the clinician.

(ii) At the time an investigator concludes that it reasonably appears the conduct that was reported as psychological abuse actually occurred and that the conduct met other criteria included in the definition of psychological abuse (i.e. the conduct was intentional or reckless) the agency director, or designee, will notify the clinician responsible for completing the assessment to determine the effect, if any, the conduct had on the individual who was allegedly abused. If it does not appear that the conduct actually occurred as reported, or does not meet the criteria for psychological abuse, an assessment of substantial diminution is not required.

(iii) If, within five business days, the investigator cannot conclude whether the alleged conduct that was reported as psychological abuse actually occurred, an assessment may still be initiated if a clinician believes the assessment is clinically indicated based on the individual, and his or her symptoms, behavior, and

history. The clinician should notify the agency director, or designee, if it is believed the assessment is clinically indicated.

(iv) The clinician, based on his or her clinical judgment, may initiate the assessment prior to ten days after the incident was reported if an individual demonstrates a sudden or noticeable change in emotional state or behavior.

(v) If during the course of the assessment the investigator determines that it is likely that the conduct did not occur or that other criteria were not met, the investigator will inform the agency director, or designee, who must notify the clinician so the assessment can be immediately discontinued.

(vi) Informing the individual receiving services and obtaining assent: The clinician must provide the individual or his or her personal representative with information about the purpose of the assessment and how information obtained through such assessment can and may be used. If the individual does not wish to participate in the assessment process, if his or her personal representative objects, or if the individual and/or their personal representative do not understand the purpose of the assessment or how such information will be used, the interview should not be completed. In such situations, the clinician can review records and use other methods of assessment such as interviewing support staff to assess any observed or reported changes or diminution in the individual's behavior, symptoms, or functioning for a sufficient period of time after the incident.

(vii) Due to the complexities associated with interviewing individuals with cognitive, developmental, and/or psychiatric disabilities, and the complexities associated with assessing the degree of impact a custodian's conduct might have on an individual, it is possible that the time needed to complete the assessment will exceed 30 days. Pursuant to OPWDD regulations (subdivision 624.5(n)(2)), investigations may only exceed 30 days with documented justification. Such documentation must clearly identify the reasons for extending the assessment and specifically document how the extension is critical for making a determination of the effect of the conduct on the individual. An extension may not be used for the convenience of staff. Therefore, additional time needed to complete the assessment must be documented in a written justification for the extension. The clinician must communicate with the investigator regarding the indicated timeframe for the assessment so that the agency remains in compliance with this requirement.

(viii) A health assessment, including an assessment of pain or discomfort, should be completed to identify and evaluate any physical or medical signs or symptoms that the individual receiving services may experience and to assess any effect these symptoms could have on an individual's symptoms or behavior. The health assessment may be completed by a registered nurse (RN), nurse practitioner (NP), physician's assistant (PA), medical doctor (MD), or doctor of osteopathic medicine (DO). A dentist (DDS or DMD) might also complete the health assessment if symptoms are related to oral health or hygiene.

(ix) Findings from the assessment to provide evidence of the effect of psychological abuse must be used to formulate an opinion regarding the effect that the incident has had, or could potentially have had, on the individual. The report, which summarizes findings from the assessment, should indicate whether there is evidence that the custodian's conduct caused, or was likely to cause, a substantial diminution of the emotional, social, or behavioral development or condition of the individual receiving services. Findings from the assessment should also guide treatment recommendations. The report must be submitted to the agency director as well as the investigator assigned to the investigation.

**G. Report:**

The appointed clinician must prepare a written report that documents the totality of findings from the assessment. The report must contain the following elements:

(1) A statement regarding the purpose and reason for the assessment;

(2) A statement confirming the following:

(i) The purpose of the assessment was explained to the individual and/or his or her personal representative,

ii) The individual, or his or her personal representative, understood the purpose of the assessment, and

iii) The individual, or their personal representative, agreed to, or objected to, the assessment.

(3) A statement describing the type of relationship the clinician has with the individual receiving services (e.g., first time encounter with the individual; ongoing therapeutic relationship; assigned therapist);

(4) Identification of assessment techniques used, such as records reviewed, data gathered and considered, interview statements and findings, behavioral observations, findings from the health assessment, etc.;

(5) A description of the conditions, both environmental and personal, observed during the various segments of the assessment;

(6) A summary of the individual's background and history, particularly significant life events including a history of victimization, trauma, and abuse that is relevant to this assessment;

(7) A review of relevant information gathered from the assessment and information which was used to establish the clinical opinion. Information may include: behavioral observations; symptoms, reactions, or complaints communicated verbally or nonverbally by the individual; verbal or nonverbal indicators of psychological harm or distress; data and findings from the meal, sleep, mood, behavior, or communication log(s); and clinically significant information from interviews and the health related appraisals;

(8) A statement clearly indicating the effect the conduct had on the individual receiving services. The statement should indicate whether there is evidence that the custodian's conduct caused, or was likely to cause, a substantial diminution of the emotional, social, or behavioral development or condition of the individual receiving services.

(9) Clinical recommendations may be provided as appropriate.

# APPENDIX 2 - OPWDD Guidelines for Responding to Conduct Between Persons Receiving Services that would Constitute Abuse if Committed by a Custodian

## OPWDD Guidelines for Responding to Conduct between Persons Receiving Services that would Constitute Abuse if Committed by a Custodian

8/24/2016

### A. Background:

The Protection of People with Special Needs Act (PPSNA) established the Justice Center and reformed policies and procedures concerning incident management effective June 30, 2013. As a result, "conduct between persons receiving services that would constitute abuse" is classified as a "significant incident" and is defined in SSL 488(1)(i)(1). OPWDD added a conforming definition of "conduct between persons receiving services that would constitute abuse" in 14 NYCRR paragraph 624.3(b)(9)(ii)(a).

Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/IIDs), including state operated developmental centers, must also comply with federal regulations in 42 CFR Part 483 including implementing protections for all individuals involved in the event as specified in §483.420. In some instances, the federal requirements are more stringent than the requirements in Part 624. ICFs, as with all OPWDD certified and operated programs, must protect individuals from all forms of abuse, neglect, or mistreatment, including abuse, neglect, or mistreatment between individuals receiving services (see §483.420(a)(5)). All agencies, including ICF/IIDs, must take immediate actions to address circumstances where abuse, neglect, or mistreatment have occurred and staff must proactivity prevent abuse from occurring or reoccurring.

### B. Purpose:

Conduct between persons receiving services that would constitute abuse if committed by a custodian must be responded to seriously in order to protect the rights of individuals receiving services and to maintain a safe environment. This document provides guidance so agencies can respond appropriately and therapeutically to individuals who demonstrate challenging behavior that, if committed by a custodian, would constitute physical or psychological abuse, as described in paragraphs 624.3(b)(1) and 624.3(b)(3), while fully complying with 14 NYCRR Part 624 (Reportable Incidents and Notable Occurrences). The purpose of this document is to offer procedures that protect the rights of individuals and guide staff in responding appropriately and therapeutically to individuals who demonstrate **untoward** challenging behavior, **without an intent to cause harm or injury**, toward another person receiving services. Conduct between individuals that is not untoward or when the individual intended to cause harm or injury to another person receiving services must be reported to the Justice Center and/or OPWDD as required in Part 624.

### C. Applicability:

1. This guidance document applies to the facilities and programs that comply with 14 NYCRR Sec. 633.16. Section 633.16 applies to:

    a. all residential facilities certified or operated by OPWDD, including ICFs and family care homes;

    b. all facilities certified by OPWDD, except:

        i. free standing respite;

        ii. Article 16 clinics; and

        iii. the Institute for Basic Research in Developmental Disabilities;

    c. day habilitation services (whether or not provided in a certified facility);

    d. prevocational services (whether or not provided in a certified facility); and

    e. community habilitation.

2. Only the programs specified above have the **option** of implementing the procedures outlined in this guidance document. Programs that choose to use these guidelines must practice in full compliance with the requirements and procedures contained herein. Programs that choose not to use these guidelines must respond to significant incidents in accordance with Part 624 or 625 as applicable.

3. Programs and facilities subject to OPWDD oversight that are not listed above are prohibited from implementing the procedures in this guidance document. Therefore, the program or facility must immediately notify the Justice Center and/or OPWDD (as appropriate) following any significant incident.

4. This guidance document pertains only to individuals who demonstrate conduct toward another person receiving services, without the intent to cause harm or injury, that if committed by a custodian would be considered physical or psychological abuse as defined in paragraphs 624.3(b)(1) and (3).

   Events involving conduct between persons receiving services that are not under the auspices of an agency must be responded to in accordance with Part 625. The procedures in this document do not apply in such situations.

   Intermediate Care Facilities, including state operated developmental centers, must also comply with the requirements of 42 CFR 483. In some instances, these federal requirements are more stringent than the requirements set forth herein.

**D. Definitions for purposes of this guidance document:**

1. **Abuse**, for purposes of this guidance document, is limited to physical abuse and psychological abuse which are classified as reportable incidents and are defined in paragraphs 624.3 (b)(1) and 624.3(b)(3).

2. **Behavior Support Plan (BSP)** is defined in paragraph 633.16(b)(28) and is a person-centered plan that outlines specific interventions to be used by staff to address or manage and individual's challenging behavior while teaching or promoting the individual's use of adaptive behavior. A protocol for responding to conduct between persons receiving services that would constitute abuse if it were committed by a custodian must be incorporated into a new or existing BSP that meets the requires established in 14 NYCRR 633.16.

3. **Challenging Behavior** is defined in section 633.16(b)(4) and is behavior that interferes with one's performance of daily activities and undermines the potential for independence as well as may violate the rights of others. For purposes of this guidance document, an individual's untoward conduct toward another person receiving services that would constitute abuse if committed by a custodian is considered to be a challenging behavior.

4. **Functional Behavior Assessment (FBA)** is defined in paragraph 633.16(b)(2) and is a process used to identify and describe challenging behavior(s) and any possible factors and circumstances surrounding the challenging behavior(s). Findings from the FBA are used to identify or develop interventions incorporated into the person-centered BSP.

**E. Procedure:**

**I. Identify an individual who demonstrates conduct toward another individual receiving services that would constitute physical or psychological abuse if conducted by a custodian.**

1. Individuals who demonstrate untoward behavior toward another person(s) receiving services can be identified by any staff member (e.g., program planning/ support team, agency administrator, incident management or quality assurance staff).

2. Individuals who demonstrate such untoward conduct should be referred to the individual's treatment team leader, or equivalent, and/or psychologist who will schedule a team meeting (e.g., interdisciplinary, treatment, or planning team) to discuss and review the individual's behavior.

3. The agency/program should make arrangements to collect data on the untoward behavior which will be part of the Functional Behavioral Assessment (FBA) as described in section 633.16(d). Data should track the type, frequency, and severity of the conduct, antecedents to the behavior, and outcomes as a result of the conduct.

**II. Initial program planning/support team meeting to review the individual and the challenging behavior.**

1. The team shall meet to review the individual and their behavior(s) that would constitute abuse if committed by a custodian. This review should include a discussion about the behavior and circumstances surrounding the individual's conduct as well as identifying the antecedents, frequency, intensity, duration, location, time of day, and outcomes associated with the behavior. The team must also begin taking the necessary steps to determine whether the challenging behavior is attributed to the individual's disability and condition.

2. Positive behavioral approaches that can address the individual's untoward and challenging behavior should be implemented as described in paragraph 633.16(c)(4). Approaches could include environmental and behavioral interventions (e.g., adjusting the individual's schedule, sitting out of arm's reach of peers), therapeutic treatment, or supportive counseling, to the extent possible. Interventions should be offered in effort to reduce or eliminate the challenging behavior. The team must maintain documentation on all positive approaches attempted and the individual's response to such approaches.

3. The team should establish a means for maintaining documentation and behavioral data tracking as described in section 633.14(d).

**III. Review of the less restrictive intervention(s) offered to the individual and their response to the intervention(s).**

1. The team will meet to review the positive behavioral approaches that were offered to the individual and review the corresponding behavioral data.

2. If the individual is responsive to counseling and/or the positive behavioral approaches offered, the conduct is no longer considered challenging behavior and a BSP is not necessary as less restrictive interventions can be used to successfully address the behavior. In this case the agency will respond to all significant incidents in accordance with part 624. In addition, ICF/IIDs must also fully comply with the federal regulation CFR Part 483 including protecting the rights of individuals as specified in section §483.420.

3. If the individual is not responsive to the approaches described above (e.g., expresses no desire or is unable to address the behavior, denies the behavior, or is unable to understand or comprehend the communication) the clinical staff will complete an FBA to determine if a BSP that contains a protocol is appropriate to address the challenging behavior.

## IV. Functional behavioral assessment (FBA)

1. The FBA must comply with the requirements set forth in section 633.16(d) and must be completed prior to the development of a BSP that includes a protocol.

2. The FBA is used to identify factors that are associated with such untoward behavior (see 633.16(d)(1)(iii)) and to obtain information for effective intervention planning. In addition to the factors listed in the regulation, the team should also consider other contextual factors that could be associated with the behavior including communication deficits, sensory experiences, unmet internal needs, and past history.

## V. Program planning/support team reviews the FBA to determine if a BSP that contains a protocol for responding to conduct between persons receiving services that would constitute abuse is indicated.

1. The team will meet to review the findings from the current FBA. The current FBA may incorporate findings from any prior FBAs when appropriate. The team, in conjunction with the individual or their guardian, will decide if a protocol to address untoward behavior(s) toward another individual is clinically indicated.

   a. If the team and/or the guardian determine that a protocol is not clinically indicated or appropriate, the agency will continue to report the conduct as a significant incident in accordance with Part 624 (and in accordance with CFR Part 483, where applicable).

   b. A protocol should <u>not</u> be developed if the data and findings from the FBA is not sufficient to justify the use of a protocol to address such conduct. Further, <u>a protocol should not be developed if it is discovered that the individual intentionally or recklessly engaged in such conduct to cause harm, physical injury or impairment (requiring treatment beyond first aid) to another person receiving services or to cause emotional distress to another individual</u>.

2. If, based on the findings from the FBA, the team determines that a protocol is indicated to respond therapeutically to the individual's conduct that would

constitute abuse if committed by a custodian, a qualified staff member is assigned to develop the protocol. Such protocol should only be developed and incorporated into a new or existing BSP when the behavior is attributed to the individual's disability and condition, as determined and documented by the treatment team and a psychologist.

## VI. Developing a BSP that includes a protocol for responding to conduct between persons receiving services that would constitute abuse if committed by a custodian.

1. A protocol to respond to such conduct between persons receiving services must be incorporated into a BSP that is fully compliant with the requirements set forth in Part 633.16 (Person Centered Behavioral Intervention), and other applicable laws, regulations, and agency-specific policies and procedures.

2. The protocol, incorporated into a new or existing BSP, may be developed by a
   a. licensed psychologist;
   b. licensed clinical social worker; or
   c. Level 1 or level 2 Behavior Intervention Specialist (BIS) (see section 633.16(b)(32)) under the supervision of a licensed psychologists or licensed clinical social worker (LCSW).

3. A protocol may be incorporated into an existing BSP and information from the existing BSP and FBA may be considered when developing the protocol.

4. The BSP developed by the team that includes the protocol for responding to conduct between individuals may only be implemented after receipt of informed consent from the individual or their consent giver. The protocol must also be reviewed and approved by the Incident Review Committee (IRC) and by the Behavior Plan/Human Rights Committee (HRC). Documentation of such consent and approvals must be maintained by the agency. Objections to the plan are subject to the processes outlined in subdivision 633.16(h). Prior to obtaining the necessary consent or approvals, or in the absence of current consent or approval (see paragraph VII(5) of this document), the agency must respond to all conduct between persons receiving services that would constitute abuse in accordance with Part 624 including reporting the incident to the Justice Center and/or OPWDD.

5. It is imperative that the rights of all individuals are protected, including all individual' right to be free from abuse or mistreatment. The agency must implement measures and safeguards to protect all individuals from peers who demonstrate untoward challenging behavior that constitutes abuse or mistreatment. Therefore the protocol must describe safeguards and interventions that staff will implement to protect the rights of peers and others who come in contact with the individual. Nothing in these guidelines prohibits any victim of the individual's conduct from reporting the event to agency administrators, the Justice Center Vulnerable Persons' Central Register (VPCR), or OPWDD.

6. The BSP containing the protocol must be prescriptive in nature and is intended to offer treatment approaches to respond to individuals who demonstrate untoward behavior that is attributed to the individual's disability or condition, towards others that could constitute abuse or mistreatment.

a. The protocol must identify the specific behavior(s) subject to the plan (e.g., bumping someone else's arm, pushing someone, yelling and stating they will harm someone) and any identified circumstances surrounding the behavior (e.g., conduct demonstrated during a particular task, conduct demonstrated prior to a particular event or transition).

b. The plan must state that the conduct is immediately reported to the Justice Center, OPWDD, and/or law enforcement in accordance with Part 624 when one or more of the following situations occurs;

   i. The demonstrated conduct differs from the behavior and/or circumstances described in the BSP, or
   ii. It is evident that the individual intended to cause injury that required treatment beyond first aid or harm to the health safety or welfare of another person receiving services, or
   iii. The conduct resulted in the individual or another person receiving services needing medical treatment beyond first aid, or
   iv. The event occurred due to staff negligence or a lack of supervision, or
   v. The individual possessed a weapon, or
   vi. A crime has been committed.

c. In the event of the circumstances described above (see VI(6)(i-vi)) the administrator or designee must ensure immediate protections for <u>all</u> individuals involved in the untoward event (see 624.5(g)).

d. The plan must include a requirement that the treatment team leader (or other designed supervisor) or Administrator on Call (AOC) is notified following the individual demonstrating the untoward conduct. The treatment team leader (or designee)/AOC confirms that the conduct is congruent with the behavior and circumstances described in the plan. The treatment team leader (or designee)/AOC is also responsible for ensuring immediate protections, particularly protections for the victim or other potential victims (see subdivision 624.5(g)).

e. The plan must require immediate examination for injury of all individuals involved in an event that could have, or has, resulted in physical harm. If an injury/injuries are identified or suspected, health care staff must be immediately notified and appropriate medical care must be provided and documented (see 624.5(g)(4)). Conduct that results in one or more injuries that require treatment beyond first aid must be immediately reported to the Justice Center Vulnerable Persons' Central Register (VPCR) and OPWDD as required in Part 624.

f. The BSP containing the protocol must outline a method for data collection (see clause 633.16(e)(2)(viii)).

g. A fading plan for the protocol must be included in the BSP as required in clause 633.16 (e)(3) (ii)(e). When the protocol is faded or discontinued, any and all conduct between person receiving services that would constitute physical or psychological abuse if committed by a custodian, which is a significant incident, must be reported to the Justice Center

and/or OPWDD immediately. The protocol must be discontinued if the individual does not engage in the conduct described in the plan for twelve (12) or fewer consecutive months.

h. The conduct and any protections implemented must be documented in the record of the individual who has a protocol for responding to conduct between persons receiving services that would constitute abuse incorporated into their BSP. In addition, documentation in the record of the individual(s) who were subject to the conduct, and a description of immediate protections, must be maintained.

## VII. Using a BSP that contains a protocol for responding to conduct between persons receiving services that would constitute abuse if committed by a custodian.

1. When the individual demonstrates such conduct toward another individual, the treatment team leader (or designee)/AOC must immediately review the plan and direct staff so that all steps in the protocol are followed as outlined and to ensure that all necessary and appropriate immediate protections are implemented and documented. This includes ensuring that immediate protections are implemented for any individual(s) subject to the untoward conduct.

2. The conduct is not reported to the Justice Center or OPWDD when the treatment team leader (or other designed supervisor)/AOC confirms that

   a. the conduct is congruent with the behavior and circumstances outlined in the protocol, and
   b. the individual did not appear to intend to harm or cause injury to the other person(s) receiving services, and
   c. there are no known injuries requiring treatment beyond first aid.

3. The clinician (BIS, LCSW, or licensed psychologist) who oversees the protocol contained in the BSP is notified of the event on the next business day. The clinician, or their designee, will provide counseling, a debriefing, or offer supports to the individual and/or any individuals involved in the event as appropriate. Supports and services offered to the individual after the event should be therapeutic in nature and address the challenging behavior to the extent possible.

4. The BSP containing the protocol and behavioral data collected with which progress in reducing the conduct can be evaluated must be reviewed/approved by the program planning/support team no less frequently than on a semi-annual basis (see 633.16(e)(2)(ix)) beginning from the date the protocol was implemented. The protocol review, a summary of the individual's progress, or lack thereof, and changes to the protocol must be documented. The team should review the protocol prior to the semi-annual review date if indicated, including when there are notable changes in the individual's behavior, symptoms, or condition which would require the team to re-evaluate or modify the interventions outlined in the protocol.

5. Informed consent, IRC, and HRC approval to use the BSP that contains the protocol must be renewed no less frequently than annually. If informed consent or IRC and HRC approval is not renewed at the annual review, the protocol will immediately cease. The specific elements of the plan must also cease if consent or approval for these elements is withdrawn.

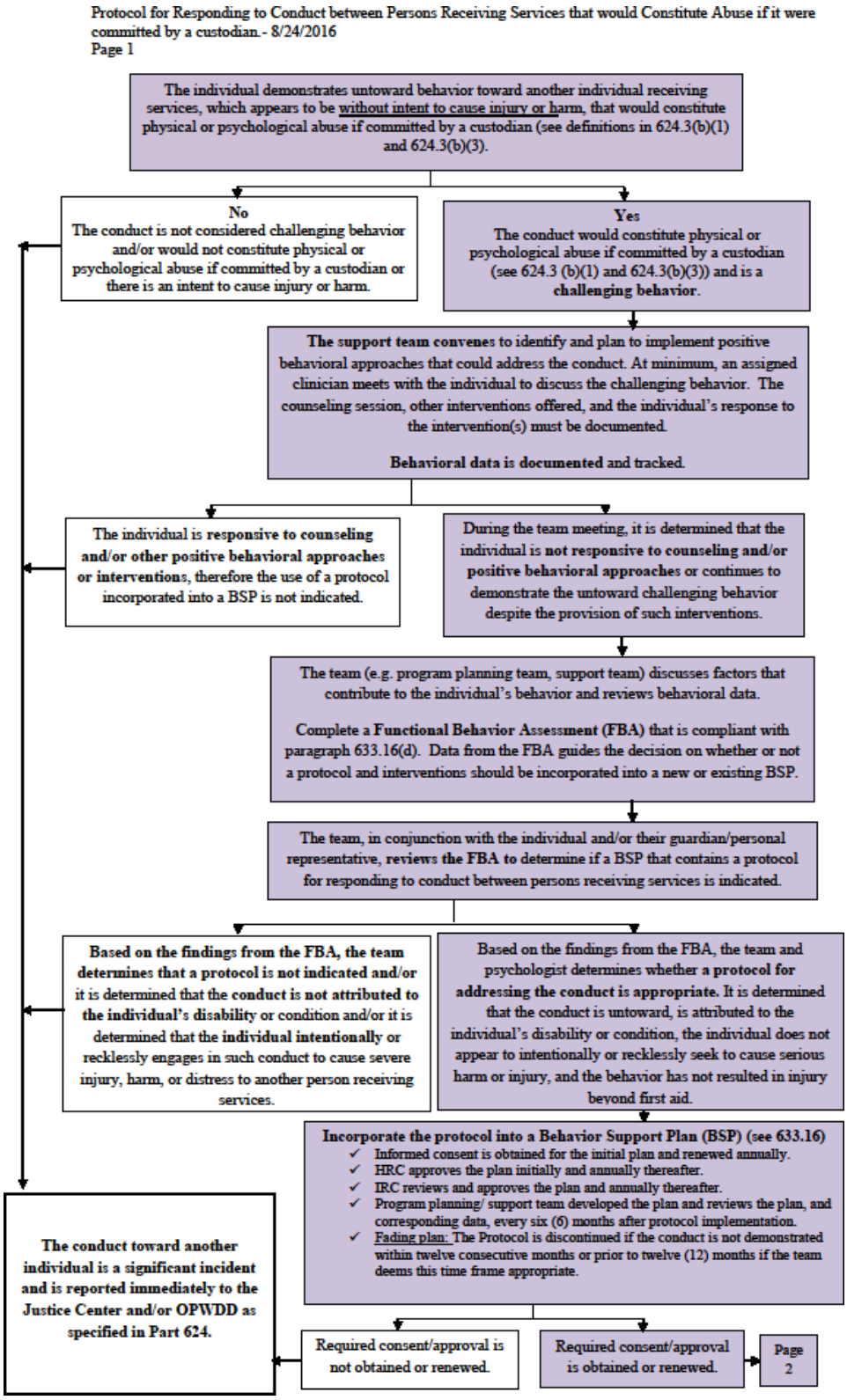
6. The team must obtain updated informed consent and IRC and HRC approval prior to the annual review date when there is a significant change in specific behavior(s) or conduct for which the protocol applies (see paragraph VI(6)(a) of this document) or when there is an essential change in the scope of the interventions included in the protocol.

7. The circumstances listed below result in the conduct being considered a significant incident. During such circumstances, a report must be made by the treatment team leader and all mandated reporters present during the occurrence or discovery of the incident to the Justice Center Vulnerable Persons' Central Register (VPCR) and/or OPWDD in accordance with Part 624.

    a. One or more members of the program planning/support team, or the agency chief executive officer/director believe that the individual intended to cause significant harm (injury beyond first aid) to the health, safety, or welfare of another person.

    b. The agency later becomes aware of an injury which required treatment beyond first aid that resulted from the conduct. This includes injury to the person subjected to the conduct or to the person who has a protocol for responding to such conduct.

    c. Subsequent information comes to light that suggests there is reasonable cause to believe the individual intended or planned to cause significant injury or harm to the health, safety, or welfare of another person receiving services.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The individual demonstrates untoward behavior toward another individual receiving services, which appears to be without intent to cause injury or harm, that would constitute physical or psychological abuse if committed by a custodian (see definitions in 624.3(b)(1) and 624.3(b)(3).
No
The conduct is not considered challenging behavior and/or would not constitute physical or psychological abuse if committed by a custodian or there is an intent to cause injury or harm.
Yes
The conduct would constitute physical or psychological abuse if committed by a custodian (see 624.3 (b)(1) and 624.3(b)(3)) and is a challenging behavior.
The support team convenes to identify and plan to implement positive behavioral approaches that could address the conduct. At minimum, an assigned clinician meets with the individual to discuss the challenging behavior. The counseling session, other interventions offered, and the individual's response to the intervention(s) must be documented.
Behavioral data is documented and tracked.
The individual is responsive to counseling and/or other positive behavioral approaches or interventions, therefore the use of a protocol incorporated into a BSP is not indicated.
During the team meeting, it is determined that the individual is not responsive to counseling and/or positive behavioral approaches or continues to demonstrate the untoward challenging behavior despite the provision of such interventions.
The team (e.g. program planning team, support team) discusses factors that contribute to the individual's behavior and reviews behavioral data.
Complete a Functional Behavior Assessment (FBA) that is compliant with paragraph 633.16(d). Data from the FBA guides the decision on whether or not a protocol and interventions should be incorporated into a new or existing BSP.
The team, in conjunction with the individual and/or their guardian/personal representative, reviews the FBA to determine if a BSP that contains a protocol for responding to conduct between persons receiving services is indicated.
Based on the findings from the FBA, the team determines that a protocol is not indicated and/or it is determined that the conduct is not attributed to the individual's disability or condition and/or it is determined that the individual intentionally or recklessly engages in such conduct to cause severe injury, harm, or distress to another person receiving services.
Based on the findings from the FBA, the team and psychologist determines whether a protocol for addressing the conduct is appropriate. It is determined that the conduct is untoward, is attributed to the individual's disability or condition, the individual does not appear to intentionally or recklessly seek to cause serious harm or injury, and the behavior has not resulted in injury beyond first aid.
Incorporate the protocol into a Behavior Support Plan (BSP) (see 633.16)
✓ Informed consent is obtained for the initial plan and renewed annually.
✓ HRC approves the plan initially and annually thereafter.
✓ IRC reviews and approves the plan and annually thereafter.
✓ Program planning/ support team developed the plan and reviews the plan, and corresponding data, every six (6) months after protocol implementation.
✓ Fading plan: The Protocol is discontinued if the conduct is not demonstrated within twelve consecutive months or prior to twelve (12) months if the team deems this time frame appropriate.
The conduct toward another individual is a significant incident and is reported immediately to the Justice Center and/or OPWDD as specified in Part 624.
Required consent/approval is not obtained or renewed.
Required consent/approval is obtained or renewed.
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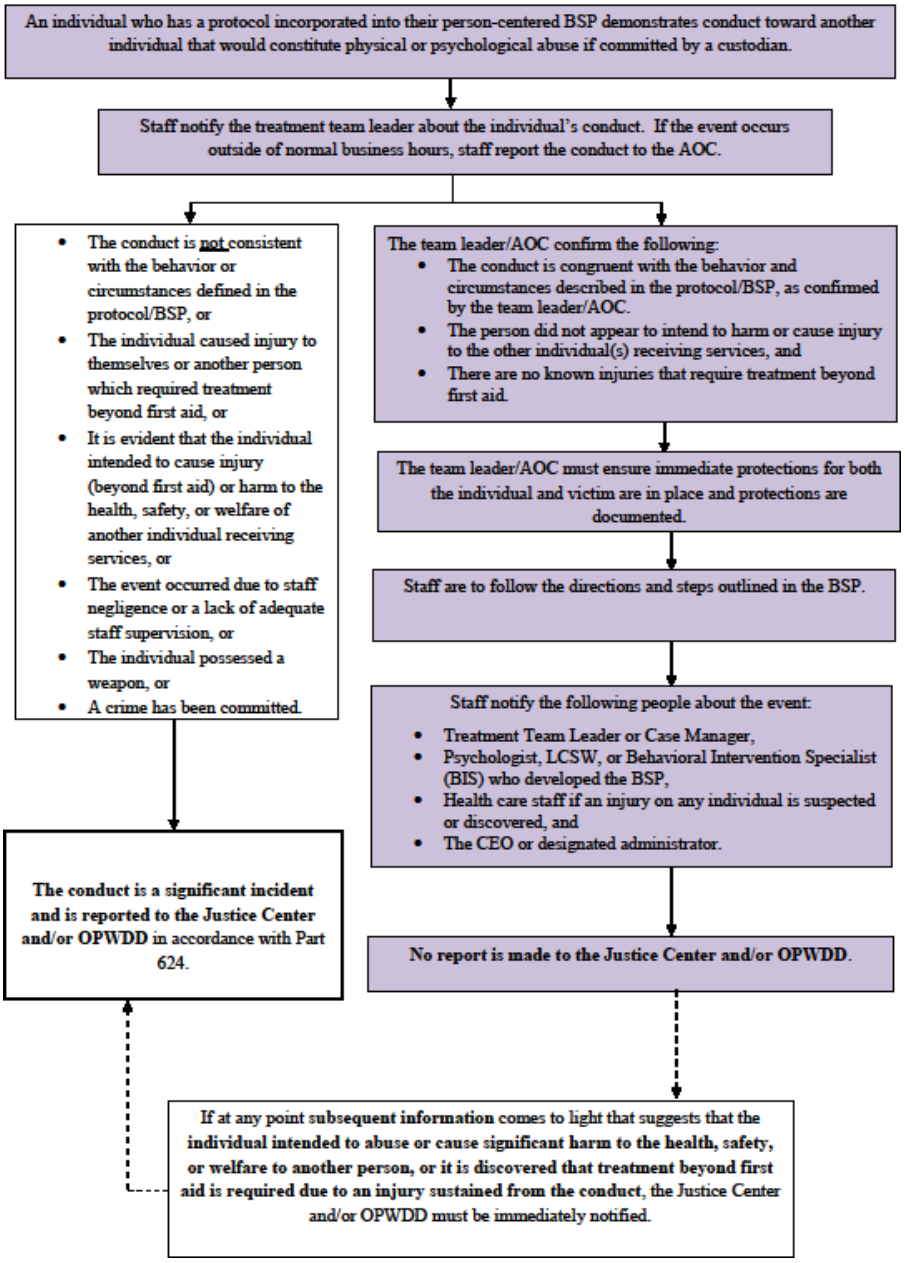

# APPENDIX 3 – OPWDD Guidelines for Frequent False Reporting of Abuse, Neglect, or Mistreatment-

# OPWDD Guidelines for Frequent False Reporting of Abuse, Neglect, or Mistreatment

**This document supersedes the Guidelines for Frequent False Reporting released 6/2/2014**

## A. Intent:

This document provides guidance so agencies can respond appropriately and therapeutically to individuals who have demonstrated a documented pattern of making false reports of abuse, neglect, or mistreatment while fully complying with 14 NYCRR Part 624 (Reportable Incidents and Notable Occurrences) and Article 11 of the Social Services Law. All reports of abuse, neglect, and mistreatment are to be taken seriously and investigated in order to protect the rights of individuals, including those with a documented history of making false reports. In addition to protecting an individual's rights, the procedures in this guidance document can reduce the potential for behavioral reinforcement that is often inadvertently provided by standard reporting and investigation procedures. Reinforcing a pattern of false reporting negatively impacts an individual's daily functioning and interpersonal relationships, and reduces an individual's potential to develop adaptive or coping skills such as problem-solving, social, and communication skills.

Intermediate Care Facilities, including state operated developmental centers, must also comply with federal regulations in 42 CFR 483. In some instances, these requirements are more stringent than the requirements set forth in this guidance document.

False reporting by persons receiving services that is not under the auspices of an agency must comply with Part 625. This guidance document does not apply to events and situations that must be reported and managed in accordance with Part 625.

## B. Applicability:

1. This guidance document applies to the facilities and programs that must comply with 14 NYCRR Sec. 633.16. Section 633.16 applies to:
   - (1) all residential facilities certified or operated by OPWDD, including ICFs/IID and family care homes;
   - (2) all facilities certified by OPWDD, except:
     - (i) free standing respite;
     - (ii) Article 16 clinics; and
     - (iii) the Institute for Basic Research in Developmental Disabilities;
   - (3) day habilitation services (whether or not provided in a certified facility);
   - (4) prevocational services (whether or not provided in a certified facility); and
   - (5) community habilitation.
2. Only the programs specified above have the option of implementing the procedures outlined in this guidance document. Programs that choose to use these guidelines must practice in full compliance with the requirements and procedures contained in this document.
3. Programs and facilities subject to OPWDD oversight that are not listed above are prohibited from implementing the procedures in this guidance document. Therefore, the program or facility must immediately notify the Justice Center and/or OPWDD (as appropriate) following a report of abuse, neglect, or mistreatment, even if the agency or program considers the report to likely be false.
4. This guidance document pertains only to reports of abuse, neglect, or mistreatment as defined in paragraphs 624.3(b)(1-8) and subparagraph 624.3(9)(ii)(b)(5) and in ICF regulation 483.420(a)(5) guidelines. Reports made in accordance with Part 625 do not fall under this guidance document.

## C. Definitions for purposes of this guidance document:

1. Many terms used in this guidance document are defined in subdivision 633.16(b). These include behavior support plan (BSP) and functional behavior assessment (FBA).

2. **Abuse** includes reportable incidents defined in paragraphs 624.3 (b)(1-7).

3. **Neglect** is defined in subparagraphs 624.3(b)(8)(i-iii).

4. **Mistreatment** is defined in subparagraph 624.3(b)(9)(ii)(b)(5).

5. **Pattern of False Reporting**:

   a. A pattern of behavior is considered to be at least three (3) unsubstantiated or false reports of abuse, neglect, or mistreatment made within six (6) consecutive months. The six-month period begins with the date the first report was made that was later deemed unsubstantiated or false. During the six months following the date that the first false report was made, the individual must have made at least 2 additional unsubstantiated or false reports for the use of a protocol to be considered. The reports must have been determined to be unsubstantiated or false following an investigation completed in accordance with Part 624. Documentation that each report was unsubstantiated, or determined to be false, must be maintained by the agency; and

   b. There must be a pattern and similarities in the type and features of the reports. Similarities could include an individual making reports in a particular setting, during a particular circumstance, during a particular time of day or on a particular day of the week, or regarding a particular type of event; and

   c. The reported conduct, if it were true, must meet the definition of abuse, neglect, or mistreatment.

6. **Expedited Review:**

   a. Involves an investigator, designated by a CEO, reviewing a report made by an individual who has a Protocol for False Reporting.

   b. The review must commence immediately once a report is made by an individual.

   c. Information from the review is placed into a written report in the form and format specified by OPWDD (available on the OPWDD IMU website: http://www.opwdd.ny.gov/opwdd_resources/incident_management/forms/opwdd160 The report must be completed within 24 hours following the report made by an individual.

## D. Procedure:

### I. Identifying individuals for a Protocol for False Reporting

1. Individuals with a documented pattern of making false reports of abuse, neglect, or mistreatment can be identified by any staff member including a member of the program

planning/ support team or by an administrator designated by the agency director or chief executive officer.

a. Any member of the program planning/support team notified that an individual might demonstrate a pattern of false reporting of abuse, neglect, or mistreatment should notify the administrator designated in agency policy.

b. The designated administrator should confirm that the individual has demonstrated a pattern of making false reports of abuse, neglect, or mistreatment as defined in Section C(5) of this document. The designated administrator can decide whether to implement a Protocol for False Reporting only if he/she confirms, through review of the individual's incident history, that the individual has demonstrated a pattern of making false reports. The designated administrator must maintain written documentation that confirms the individual has demonstrated a pattern of false reporting as defined above, if the individual will have a Protocol for False Reporting.

2. If the designated administrator cannot verify that a "pattern of false reporting" exists, or if the designated administrator decides not to implement a Protocol for False Reporting, then all reports of abuse, neglect, or mistreatment made by the individual must be immediately reported to the Justice Center and/or OPWDD in accordance with Part 624.

3. Efforts must be made to support the individual in effort to address the behavior of making false reports prior to the development of a Protocol for False Reporting. The designated administrator must notify a member of the clinical staff (psychologist, social worker, counselor, etc.). The clinician will attempt to discuss this pattern of false reporting with the individual in a therapeutic manner, if the individual is capable of participating in such discussion, in order to gather more information about, and attempt to resolve, the behavior. The agency must maintain documentation of this counseling and less restrictive or supportive interventions offered to address the behavior.

a. If the individual is responsive to counseling or another less restrictive intervention and the behavior can be addressed without implementing a Protocol for False Reporting, then the agency will respond to all reports of abuse, neglect, or mistreatment in accordance with Part 624 (and Part 483, where applicable).

b. If the individual is not responsive to counseling (e.g., expresses no desire to address the behavior, demonstrates continued false reporting despite the counseling intervention, denies the behavior, or is unable to understand, comprehend, or participate in the counseling) the clinical staff member will inform the designated administrator who will arrange for a meeting of the program planning/ support team. The individual's response to the counseling should be documented in the FBA (Functional Behavioral Assessment; See paragraph 633.16 (b)(2) for the definition of FBA).

## II. Program planning/ support team review

1. The designated administrator will coordinate a meeting with the program planning/support team that includes the individual, family and/or guardian, and a clinician to discuss possible factors that contribute to the individual making false reports. Documentation of the meeting and identified factors that contribute to the behavior shall be maintained. Factors that shall be discussed and considered include:

    a. Cognitive Impairment: Some individuals experience cognitive impairment or deficits that result in them misunderstanding or misinterpreting situations. These individuals may perceive a situation differently than others do, and therefore might be prone to making reports that are repeatedly deemed false.

    b. Psychiatric or Neuropsychiatric Disorder: Some individuals experience symptoms of an active psychiatric or neuropsychiatric disorder that results in them perceiving situations inaccurately. Further, they may be predisposed to believing and making repeated, frequent, or stereotyped statements that could be considered a false report.

    c. Unmet internal needs: Individuals who feel powerless, ignored, in need of attention, or want to avoid a situation may make false reports to achieve a secondary gain such as obtaining or diverting attention, avoiding an activity, or avoiding a person.

    d. Personal factors: An individual may demonstrate personality traits that are associated with making false reports.

    e. Health factors: Some individuals experience medical conditions or symptoms that can result in physical or physiological sensations that cause a person to be more sensitive to touch or pain or render them more susceptible to illness or injury.

    f. Historical event: Historical events or experiences, particularly involving trauma or abuse, can contribute to an individual's behavior of making false reports.

2. After consideration of the factors that are associated with the behavior, the team will determine if a Behavior Support Plan (BSP) that contains a Protocol for False Reporting to address the pattern of false reporting is appropriate.

    a. If the team determines that a Protocol for False Reporting is not appropriate, the agency will respond to all reports of abuse, neglect, or mistreatment in accordance with Part 624 (and Part 483, where applicable).

    b. If the team determines that a Protocol for False Reporting is appropriate to respond to such reports, the planning team must develop a BSP in accordance with agency procedures and policy, and comply with Section 633.16 (*Person-Centered Behavioral Intervention).* The Protocol for False Reporting cannot be implemented until informed consent is obtained. Paragraph III(4)(c) of this document provides additional guidance for consideration when informed consent is not provided for the use of a plan. Any report of abuse, neglect, or mistreatment made by the individual

prior to obtaining the necessary consent or approvals to use the plan shall be responded to in accordance with Part 624.

## III. Development of a Behavior Support Plan (BSP) that includes a Protocol for False Reporting

1. The BSP that includes the Protocol for False Reporting must be developed by a Behavior Intervention Specialist (BIS), licensed psychologist, or licensed clinical social worker.

2. A Functional Behavior Assessment (FBA) that includes the required elements set forth in subdivision 633.16(d) must be completed prior to the development of a BSP that includes a Protocol for False Reporting. The purpose of the FBA is to evaluate the individual's pattern of making false reports (i.e., the challenging behavior that is the target of the plan) by identifying factors that contribute to the pattern of behavior and circumstances that make it more likely for the individual to make a false report. A BSP containing a protocol may only be implemented when the FBA data and findings justify the implementation of a Protocol for False Reporting.

3. Information from the FBA will be used to guide the development of a Protocol for False Reporting which is contained in a BSP. If an individual has an existing BSP to address other challenging behavior(s), information from the existing FBA may be considered when developing the Protocol for False Reporting.

4. The BSP, including the Protocol for False Reporting, may only be implemented after receipt of informed consent and must be reviewed and approved by the Incident Review Committee (IRC) and by the Behavior Plan/Human Rights Committee (HRC) prior to implementation. Documentation of consent and HRC and IRC approval must be maintained. Prior to approving the plan, the IRC must confirm, and maintain documentation to support, that there have been three (3) false reports made within six (6) consecutive months (see section C(5)- pattern of false reporting).

    a. There may be extenuating circumstances whereby an individual demonstrates a pattern of false reporting but the team is unable to obtain informed consent for the use of the protocol.

    b. Such extenuating circumstances occur when

        i. the individual demonstrates a pattern of false reporting, and
        ii. the individual continues to demonstrate the challenging behavior of false reporting despite using less restrictive and supportive interventions, and
        iii. the team deems a Protocol for False Reporting clinically indicated based on the findings from an FBA, and
        iv. the individual's pattern of false reporting has resulted in negative or maladaptive outcomes for the individual and such consequences have been documented by the team.

c. When such extenuating circumstances are present, a member of the treatment team may request that the plan be reviewed by the clinical team at central office. The clinical team will make recommendations for addressing the challenging behavior as appropriate. Such review can be requested by contacting opwdd.behavioral.intervention.regulation@opwdd.ny.gov

5. The BSP containing the Protocol for False Reporting must be prescriptive in nature and specify both the types of reports the plan applies to and the steps to be followed. The plan must also include the following:

   a. Identification of the specific type of report(s) and/or circumstance(s) subject to the plan (e.g., reports of physical, sexual, or psychological abuse; reports following a disagreement with a staff member or peer; or reports made prior to a task or event that the individual wishes to avoid). The plan must state that in the event a report differs from the behavior specifically described in the BSP, immediate reporting to the Justice Center and/or OPWDD in accordance with Part 624 is required. In this instance, the person contacting the Vulnerable Persons' Central Register (VPCR) should notify the Justice Center and/or OPWDD that the individual has a Protocol for False Reporting but that the individual's report differs from the behavior described in the plan.

   b. The plan must require that staff notify the chief executive officer (or designee) following a report of abuse, neglect, or mistreatment that is the specific type of report stated in the Behavior Support Plan. The chief executive officer (or designee) is responsible for ensuring immediate protections (see subdivision 624.5(g)). The plan must also include a provision that the party who consented to the plan is also notified of the report.

   c. The plan must include immediate examination for injury upon the individual making a report that could have resulted in physical harm. If any injury is identified or suspected, appropriate medical care must be provided and health care staff must be immediately notified. Documentation requirements are set forth in subparagraph 624.5(g)(4).

   d. The plan must also specify documentation requirements pertaining to the report and the protections implemented.

   e. A fading plan for the Protocol for False Reporting must be included in the BSP as outlined in clause 633.16 (e)(3) (ii)(*e*). When the section of the plan pertaining to the protocol is faded or discontinued, any and all subsequent reports of abuse, neglect, or mistreatment must be reported to the Justice Center and/or OPWDD immediately. The Protocol for False Reporting must be discontinued if the individual does not make one report determined to be false in six (6) consecutive months.

6. A BSP containing a Protocol for False Reporting, and related data collected, must be reviewed by the program planning/support team, and IRC, every three months beginning from the date the Protocol for False Reporting was implemented. This review should include assessing the types of reports made by the individual, considering conclusions from any written reports, review of the individuals' response to the Protocol for False Reporting that is contained in the behavior support plan, and the efficacy of the interventions designed to address false reporting that are included in the protocol.

    a. The designated administrator must ensure that the program planning/support team review is documented. Documentation must include a summary of the individual's progress, or lack thereof, as well as any suggestions or revisions to the BSP and Protocol for False Reporting.

    b. The designated administrator must forward the documentation of the review to the IRC which will approve or deny continuation of the plan that contains the Protocol for False Reporting. The decision of the IRC must be documented. IRC approval is required for the continuation of the plan.

7. Informed Consent to use the BSP that contains the Protocol for False Reporting must be renewed annually. The HRC must also review and approve the plan at least annually. If informed consent or HRC approval is not renewed, the protocol will immediately cease. See section III paragraph 4 on how to proceed in the absence of informed consent.

8. The designated administrator must maintain copies of all reports including reports that document action(s) taken to protect the individual and/or address the pattern of making false reports, as well as findings from expedited reviews.

9. The CEO/Director or their designated administrator must provide OPWDD's Incident Management Unit with a copy of the Protocol for False Reporting for all individuals who have such plan in place. This information is to be submitted to incident.management@opwdd.ny.gov at the time the plan is implemented. OPWDD must also be notified, using the email address above, when a plan is discontinued or faded. The information provided to the OPWDD Incident Management Unit pertaining to any Protocol for False Reporting will be provided to the New York State Justice Center as appropriate.

## IV. Using a Behavior Support Plan that contains a Protocol for False Reporting

1. Once an individual, who has a Protocol for False Reporting, reports abuse, neglect, or mistreatment, a review of the BSP that contains the protocol must be completed immediately by the designated administrator so that all steps and procedures in the plan are followed as outlined.

2. The designated administrator is responsible for requiring that all necessary and appropriate immediate protections are implemented.

3. If an individual makes a report that is consistent with the behavioral pattern specified in the BSP, which contains a Protocol for False Reporting, the plan must require notification of a trained investigator designated by the chief executive officer or designee. The investigator must be notified within one hour after the report was made. Investigators are assigned in accordance with paragraph 624.5(h)(7).

4. The investigation is considered an expedited review and must commence immediately once the report is made by the individual, following subparagraphs 624.5(h)(2)(ii)(a-d).

## V. Completion of the Investigation

1. The investigation and written report in the form and format specified by OPWDD must be completed within 24 hours following the report made by the individual.

2. The assigned investigator will forward the written report from the expedited review to the designated administrator, chief executive officer or designee, and IRC chair.

3. The designated administrator and chief executive officer, or designee, must review the written report from the expedited review as soon as possible but not longer than 24 hours after receipt of the report. The designated administrator shall retain all documentation.

    a. If the written report indicates there is no reasonable cause to suspect that the abuse, neglect, or mistreatment occurred, **and** the chief executive officer or designee agrees that there is no reasonable cause to suspect that the abuse, neglect or mistreatment occurred a report is not made to the Justice Center.

        i. In this instance the written report shall be sent to, and retained by, the IRC Chair and the CEO or designee.

        ii. The findings from the expedited review or report of conclusions must be uploaded into OPWDD's Incident Report and Management Application (IRMA).

        iii. This documentation of the expedited review, as well as other related documentation, is maintained to provide evidence that the Protocol for False Reporting was correctly followed.

        iv. The following parties are also notified of the outcome:

            1. The program planning/support team,
            2. Individual,
            3. Involved employee(s), and
            4. Person who provided consent for the plan.

b. During the circumstances listed below a report must be immediately made, by the appropriate administrator and all mandated reporters present during the occurrence or discovery of the incident, to the Justice Center Vulnerable Persons' Central Register (VPCR) and/or OPWDD in accordance with Part 624. The circumstances listed below result in the report being considered a reportable incident. When these situations arise, the designated administrator is responsible for ensuring immediate protections are in place for the individual.

   i. Upon review of the written report, the designated administrator, chief executive officer, and/or IRC disagree with the conclusion that there is no reasonable cause to suspect that the abuse, neglect, or mistreatment occurred.

   ii. Upon review of the written report, the designated administrator, chief executive officer, or IRC find reasonable cause to believe that the report is true or that findings are inconclusive.

   iii. During the process of conducting the expedited review it is discovered that the individual experienced an injury of unknown origin or an injury that may be associated with the report made by the individual.

   iv. The expedited review cannot be completed within twenty-four hours.

   v. An expedited review initially determined that there is no reasonable cause to suspect that the abuse, neglect, or mistreatment occurred; however, subsequent information comes to light that suggests there is reasonable cause to believe that the report is true.

Please contact Ms. Leslie Fuld (Leslie.Fuld@opwdd.ny.gov) or Dr. Virginia Scott-Adams (Virginia.l.Scottadams@opwdd.ny.gov) should you have questions about the information contained in this document.

c: Provider Associations
Willowbrook Task Force
Central Office Leadership Team
Division of Quality Improvement Staff

# APPENDIX 4 – Guidelines for Willowbrook Incident Reporting

This information can be found at the following link:

https://opwdd.ny.gov/willowbrook/incident-management

# APPENDIX 5 - Guidance Documents

Jonathan's Law Requirements
OPWDD Required Background Checks (February 2014) Revised
Part 624 OPWDD and JC Death Report Requirements, effective June 30th, 2013
Part 625 Events/Situations Not Under the Auspices of an Agency
Types of Incidents Effective January 1, 2016
Notification Sheet – Significant Incidents, Notable Occurrences

The above information can be found at the following link:

http://www.opwdd.ny.gov/opwdd_resources/incident_management/justice_center

# APPENDIX 6 - Learning About Incidents Brochure

This information can be found at the following link:

www.opwdd.ny.gov/learning-about-incidents-brochure

# APPENDIX 7 – Examples of "Under The Auspices" vs. Not "Under The Auspices"

| EXAMPLES | |
|---|---|
| **Under the Auspices** | **Not Under the Auspices** |
| • The MSC visits an individual at their apartment. The MSC notices they have no food. When asked, the individual states that their residential habilitation staff helps them buy groceries with their benefit card and then takes the groceries home with them. The individual reports this happens all the time. | • The MSC visits an individual at their apartment. The MSC notices they have no food. When asked, the individual states that their brother helps them buy groceries with their benefit card and then takes the groceries home with them. The individual reports this happens all the time. |
| • An individual is out in the community accompanied by day habilitation staff. The individual falls and is transported to the ER. An x-ray is taken and is positive for a fracture of the wrist. The individual is admitted to the hospital for surgery related to the injury. | • An individual is out in the community independently. The individual falls and is transported to the ER. An x-ray is taken and is positive for a fracture of the wrist. The individual is admitted to the hospital for surgery related to the injury. |
| • A direct support professional (DSP) accompanies an individual while on a community outing. A community member reports to the agency that they witnessed the DSP punch the individual in the face. | • An individual visits family at home. Upon arrival back to the IRA the individual reports being "hit" by a sibling causing a large bruise on his/her face. |
| • Two individuals at an IRA get into a physical altercation over the television remote. The altercation results in one individual receiving three stitches to their forehead. | • An individual at their family home gets into a physical altercation with a family member over the television remote. The altercation results in the individual receiving three stitches to their forehead. |
| • A direct support professional failed to provide required enhanced supervision to an individual while at the certified residence. As a result, the individual left the residence and is missing. They are found by police down the street. | • An individual receiving MSC services lives with their family. The family tells the individual they can ride their bicycle independently to a local store. The individual does not return and the family reports them missing. The individual is later found across town by the police. |
| • An individual is riding a bus operated by a registered (contracted) provider. The individual tells their residential staff that they were sexually assaulted by the bus monitor on the bus. | • An individual is riding the bus (public transportation) independently to and from work and is sexually assaulted by a community member on the bus. |
| • A family member visits an individual at their certified residence. Residence staff are to provide 1:1 enhanced supervision but the staff is not in the room. Another staff witnesses the family member slapping the individual for "talking back to them". | • A family member comes to visit an individual at their residence and staff witness the family member slapping the individual for "talking back to them". |
| • A community habilitation staff member, while on an outing with an individual, stops to buy or sell drugs. | • An individual reports to her community habilitation staff that his stepfather sells drugs out of the family residence. |
| • An individual is admitted to a nursing home and is discharged from the IRA. Two weeks later the individual passes away at the nursing home. | • An individual lived with their family and received Care At Home services only. The individual passed away due to a stroke. . |

# APPENDIX 8 - Statewide Standing Committee on Incident Review Standards of Excellence for Incident Review Committees

# Incident Review Committee (IRC) Standards of Excellence

Enclosed in this section are the IRC Standards of Excellence. These standards are meant to be used as a guidance tool for your agency's Incident Review Committee (IRC). This document points to many of the responsibilities of the Committee and suggests best practices to agencies in meeting those responsibilities. Agencies are encouraged to provide each member of the Committee with a copy of this document. For a complete list of IRC responsibilities, please refer to 14 NYCRR 624.7.

***STANDARD #1:*** ***The Incident Review Committee is recognized throughout the agency as autonomous.***

To ensure the autonomy of the Incident Review Committee:

1. The Chief Executive Officer is responsive and accessible to the Incident Review Committee.
2. The Chief Executive Officer ensures consistent response by agency administrators to the Incident Review Committee's recommendations and/or actions.
3. The Chief Executive Officer is actively involved in the process of determining membership and determining there is no conflict of interest.
4. Membership requirements, responsibilities, and functions are clearly set forth in agency policy, and are made known to staff.
5. Membership is diverse with regard to experience, clinical expertise, roles within the agency, and sensitivity to the needs of persons receiving services.
6. When the investigation is completed by the agency the Incident Review Committee has the authority to request and receive further information and to review the accuracy of those reports.
7. All members of the Incident Review Committee participate on a regular basis.
8. IRC members are empowered to provide input freely and without constraint.

***STANDARD #2:*** ***The Incident Review Committee reviews events from the aspect of both the individual event and broader related systemic issues, and, when necessary, makes recommendations in either or both areas.***

To ensure that the Incident Review Committee can make additional recommendations to prevent future incidents from occurring:

1. The Incident Review Committee is able to access information on previous similar events in which the involved person and/or others were included.
2. The Incident Review Committee is able to access information on the involved person's previous history with respect to incidents.
3. The Incident Review Committee is made aware of and reviews all recommendations. Documentation that the recommendations were implemented is provided to the IRC Chair. Recommendations not implemented as originally discussed will include justification.

***STANDARD #3:*** ***Agency administrators and staff respond to the recommendations of the Incident Review Committee.***

Agency follow-through on Incident Review Committee recommendations is evidenced by the presence of an agency system:

1. Documenting Incident Review Committee recommendations which reflect consideration of both the individual event and broader systemic actions or issues, and, thereby, could prevent similar occurrences in the future.
2. Documenting the response to the recommendations.
3. Maintaining documentation of the implementation of the recommendations.
4. Monitoring the effectiveness of completed recommendations.

***STANDARD #4:*** ***Each member of the Incident Review Committee is knowledgeable regarding the purpose and function of the Incident Review Committee, and of his or her role and responsibilities as a member of that committee.***

All members of the Incident Review Committee are knowledgeable about the purpose and function of the Incident Review Committee, and of their roles and responsibilities and committee members should be particularly knowledgeable about what constitutes a thorough investigation and be able to recognize and recommend appropriate action when an investigation, completed by the provider agency, is not adequate, there is documentation that:

1. Orientation including confidentiality requirements has been provided to each member prior to becoming active on the Incident Review Committee.
2. Each member has access to Part 624, Part 625, and Part 633, and any applicable agency policies or procedures, with updates as they occur.
3. Ongoing training is provided to all members.

***STANDARD #5:*** ***The management and review of incidents is complete.***

To ensure that the management and review of incidents is complete:

1. Each case is monitored by the Incident Review Committee until such time as all recommendations have been implemented.
2. The minutes of the Incident Review Committee reflect the committee's monitoring activities.
3. The Incident Review Committee monitors cases which are awaiting further information beyond the agency's purview, such as the letter of determination from the Justice Center's Office of General Counsel, police action, autopsy or coroner reports.
4. The Incident Review Committee reopens cases if/when additional information is obtained and requires further action.

***STANDARD #6:*** ***The IRC routinely reports on trends in incidents and makes recommendations to inform continuous quality improvement within the agency.***

To ensure that maximum benefit is obtained from trend analysis:

1. The Incident Review Committee reviews trend analyses and uses this information to make recommendations aimed at reducing both the risk and potential harm of incidents and abuse.
2. Appropriate staff throughout the agency participate in trend analysis.
3. It is done with sufficient frequency so that hypotheses suggested by previous data are tested over time.
4. Occurrences, other than serious notable and minor notable as defined in Section 624.4, are also included in trend analysis.
5. Data elements are examined to identify variables that appear to influence the frequency and severity of incidents and abuse. For example, type, person, site, employee involvement, time, date, circumstances, etc.
6. Trend analysis is used to identify issues and opportunities for improvement in the system.

# APPENDIX 9 – Jonathan's Law Sample Letters

**Jonathan's Law Sample Letter #1**
**Acknowledgement of Request – Incident Open**
**(print on agency letterhead)**

Date

Name of Qualified Party (guardian, parent, adult child, adult sibling, spouse or consenting individual)
Address

Re: Jonathan's Law Request, dated (date of request)
Name of Individual
Master Incident Number

(Agency Name) is in receipt of your letter of dated (insert date), requesting a copy of records and documents pertaining to the reportable incident filed on behalf of your (relationship to individual and name of individual).

Please be advised that this incident is currently under investigation. In accordance with NYS Mental Hygiene Law §33.25, a copy of redacted records and documents will be provided to you in within 21 days of the date the incident is closed in accordance with NYS Mental Hygiene Law (MHL) 33.25 and 14 NYCRR 624.8.

Sincerely,

Name
Title

cc:

**Jonathan's Law Sample Letter #2**
**Acknowledgement of Request – Incident Closed**
**(print on agency letterhead)**

Date

Name of Qualified Party (guardian, parent, adult child, adult sibling, spouse or consenting individual)
Address

Re: Jonathan's Law Request, dated (date of request)
Name of Individual
Master Incident Number

Dear (Name of Qualified Party):

(Agency Name) is in receipt of your letter of dated (insert date), requesting a copy of records and documents pertaining to the reportable incident filed on behalf of your (relationship to individual and name of individual).

Please be advised that this incident has now been closed. (Agency Name) is in the process of collecting the records you have requested. A copy of the redacted records and documents will be provided to you within 21 days of the date the incident was closed in accordance with NYS Mental Hygiene Law (MHL) 33.25 and 14 NYCRR 624.8.

If you have any questions, please feel free to contact (name and contact information).

Sincerely,

Name
Title

cc:

**Jonathan's Law Sample Letter #3**

**Denial of Records Request**
**(print on agency letterhead)**

Date

Name of Requestor or Qualified Party (guardian, parent, adult child, adult sibling, spouse, or consenting individual)
Address

Re: Jonathan's Law Request, dated (date of request)
Name of Individual
Master Incident Number

Dear (Name of Requestor or Qualified Party):

(Name of Agency) is in receipt of your letter dated (insert date), requesting a copy of records and documents pertaining to reportable incident filed on behalf of (relationship to individual and name of individual). At this time, we are unable to comply with this request.

** If the request is denied because the requestor is not a qualified person

Pursuant to NYS Mental Hygiene Law (MHL) 33.25 and the NYS Office for People with Developmental Disabilities (OPWDD) regulations (14 NYCRR 624.8), these records may only be disclosed to a "qualified person." A "qualified person" is defined in MHL 33.16 as the individual receiving services, a guardian, a parent, a spouse, adult child, or adult sibling.

You are not a qualified person, therefore (agency name) cannot disclose these records to you.

** if the request is denied because the request is for records that are not disclosable under Jonathan's Law

Pursuant to NYS Mental Hygiene Law (MHL) 33.25 and the NYS Office for People with Developmental Disabilities (OPWDD) regulations (14 NYCRR 624.8), a "qualified person" may request records and documents pertaining to investigations into reportable incidents at a facility where their son, daughter, court appointed ward or spouse resides or receives services.

The records you have requested are not records that pertain to an investigation into a reportable incident involving your family member.

Under 624.8(i), you may appeal this decision. You may appeal the decision, in writing, to the incident records appeals officer at OPWDD. Your written appeal may be sent to:

OPWDD Incident Records Appeals Officer
Office of Counsel
44 Holland Avenue
Albany, NY 12229

If you have any questions, please feel free to contact (name and contact information).

Sincerely,

Name
Title

cc:

**Jonathan's Law Sample Letter #4**

**Disclosure**
**(print on agency letterhead)**

Date

Name of Qualified Party (guardian, parent, adult child, adult sibling, spouse or consenting individual)
Address

Re: Jonathan's Law Request, dated (date of request)
Name of Individual
Master Incident Number

Dear (Name of Qualified Party):

Enclosed please find a redacted copy of records and documents pertaining to the reportable incident filed on behalf of your (relationship to individual and name of individual).

PURSUANT TO SECTION 33.25 OF THE MENTAL HYGIENE LAW, THE ATTACHED RECORDS AND REPORTS SHALL NOT BE FURTHER DISSEMINATED EXCEPT THAT YOU MAY SHARE THE REPORT WITH: (I) A HEALTH CARE PROVIDER; (II) A BEHAVIORAL HEALTH PROVIDER; (III) LAW ENFORCEMENT IF YOU BELIEVE A CRIME HAS BEEN COMMITTED; OR (IV) YOUR ATTORNEY.

If you have any questions, please feel free to contact (name and contact information).

Sincerely,

Name
Title

cc:

# APPENDIX 10 - Administrative Appeal Process for Denials of Records Requested Pursuant to the 14 NYCRR Part 624 Incident/Abuse Reporting, Notification and Investigation Process - OMRDD ADM #2009-04

This information can be found at the following link:

Administrative Appeal Process for Denials of Records Requested Pursuant to the 14 NYCRR Part 624 Incident/Abuse Reporting, Notification and Investigation Process

# APPENDIX 11 - Considerations Concerning Sexual Contact and Consent

**New York State Office of Mental Retardation and Developmental Disabilities**

**Considerations for the Development of Agency Policies Concerning**
**Sexual Contact and Consent**
**1993**

## PREAMBLE

Providers of services to people with developmental disabilities have a difficult mission. They must provide care, habilitation, and support services to enable persons in their care to lead as normal lives as possible; and they must **ensure that these persons are not denied the rights accorded to others. However, providers also have a responsibility to protect these same persons from harm, particularly when there is reason to question their ability to make choices and/or decisions.** The purpose of this document is to assist providers in carrying out their responsibilities. These "considerations" are not intended to serve as regulation or policy.

## FREEDOM TO EXPRESS SEXUALITY

**People with developmental disabilities are presumed to have the ability to make decisions about some or all aspects of their lives**. However, some people with developmental disabilities may, in fact, not have the ability to make decisions regarding some or all aspects of their lives, including sexuality. Providers are expected to both respect the decisions and choices made by persons with the ability to do so (even when they disagree with those decisions or choices) and to ensure that protection is afforded to those persons who do not have the ability to make some decisions.

Every person should have the opportunity to make choices regarding social relationships, sexual expression, contraception, and decisions concerning pregnancy. Every person also has the right to privacy, confidentiality, and freedom of association. All persons in facilities operated or certified by OMRDD have the right to develop self identity, self esteem and self respect; to this end, every person should have the opportunity to access individualized education and counseling regarding sexuality, throughout his or her life. In addition, every person's religious and/or other beliefs need to be respected.

No person shall be denied the right to access clinically sound instructions on the topic of sexuality and family planning services and information about the existence of these services, including access to medication or devices to regulate conception. A person's rights also include the freedom to express sexuality as limited by one's consensual ability to do so, provided such expressions do not infringe on the rights of others; and the right to make decisions regarding conception and pregnancy pursuant to the mandates of applicable State and Federal Law.

## SEXUAL CONTACT

As used throughout this document, "sexual contact" means ...any touching of the sexual or other intimate parts of a person not married to the actor for the purpose of gratifying sexual desire of either party." (PL 130.00(3), emphasis added). Sexual contact does not include hand-holding, as hands are not considered to be "intimate parts." Nor would it include accidental touching, or touching of sexual or intimate parts when necessary as part of an employee's job requirements, as such touching is not for the purpose of sexual gratification. The "touching" of another person for the purpose of expressing closeness, friendship, or the need for reassurance or support should not be considered to be "sexual contact."

**Ability to Consent to Sexual Contact:**

As used in these guidelines, the term "ability to consent" means that an adult person (generally defined as a person who is 18 years of age or older) is capable of making a decision to engage in the type of sexual contact under consideration, with knowledge and understanding of the activity, and of conveying this decision. Thus, the evaluation of a person's ability to consent should include consideration of the following:

- The person's awareness of having the choice to engage in or to abstain from the type of sexual contact under consideration.

- The person's ability to make a choice as to whether or not to engage in the type of sexual contact under consideration.

- The person's awareness of the nature of the activity and its risks and consequences. This "awareness" relates to the type of sexual contact involved. A person's awareness may be different for different types of sexual contact. For example, a person may have an awareness of the nature of touching but not of intercourse.

- The person's understanding of what constitutes sexual expression, and the possible need for restrictions as to time, place, or behavior.

- The person's understanding that certain sexual behaviors may be regarded as unacceptable or immoral by others in the community in which he or she resides, and that if a person chooses to engage in such behaviors certain social consequences may occur.

    - The person's understanding of how to prevent pregnancy and diseases which are sexually transmitted.

- The person's understanding that sexually assaultive behavior is prohibited; and sexually exploitative behavior is inappropriate.

A person, with the ability to consent to sexual contact, may be unable to verbalize this. In this situation, a determination needs to be made as to whether the person can do so through other means of communication.

**Evaluation of Consensual Ability**

Evaluations are an essential foundation for developing individualized program plans designed to maximize the person's independence and autonomy in decision-making in those aspects of life where the person is able to do so; to identify needs for training or assistance in decision-making; and to identify areas of life where the person needs to be protected from harm or exploitation because of a lack of ability to make informed decisions.

The evaluation of a person is a highly individualized process that is based on clinical expertise; upon staff's knowledge of the person and personal observation; and the input of significant others, including family members and guardians. If an adult has the ability to make decisions concerning his or her plan, such input shall only be with the person's approval. The final evaluation is a professional process involving professional judgments. An evaluation of a person's ability to consent to sexual contact should consider those factors listed above in the section, "Ability to Consent to Sexual Contact." **It is not a "test" with right and wrong answers, and, therefore one need not necessarily "pass" each of the factors.** In reviewing a person's ability to consent, the Aability of appraising the nature of this [sexual contact] conduct (PL 130.00(5)) must be reviewed in the context of the type of sexual contact being considered. There are

people in facilities who, very clearly can or do understand the nature of a personal relationship and should be permitted to pursue a relationship. There are also people in facilities who, very clearly, cannot or do not have the ability to understand what sexual contact is or the possible negative consequences of such contact, even though they may evidence pleasurable reactions from such contact. There is no question that this group of persons cannot consent to sexual contact and that facilities are mandated to protect them from exploitation and/or harm. However, there is an even larger segment of the population in facilities for whom a more formal evaluation process is necessary. Evaluation of such persons must be very individualized and take into consideration the factors listed above, and others, including long term relationships which are clearly beneficial to both parties. All information leading up to a determination must be documented in their records. This includes documentation any time a person's behavior and/or abilities provide staff with reasonto believe that his or her decision-making ability related to sexual contact may have changed, along with the outcome of the assessment of the situation.

In conducting these evaluations, there are two things providers should remember. First, "the principle which underlies all law is that an adult citizen is presumptively entitled to all his or her rights, privileges and immunities unless limited by a court of law ('judicial competency') or by a professional judgment made under standards authorized by or otherwise acceptable under the laws ('clinical or functional competency')." ("Quality of Care Newsletter", Counsel's Corner, N.Y.S. Commission on Quality of Care, Issue 50, November-December, 1991, p.3). Second, when making professional judgments, providers are expected to apply accepted professional standards and considerations. This means that, when making a professional judgment concerning a person's ability to consent to sexual contact, decisions made by appropriate qualified professionals in a competent and thorough manner are entitled to a presumption of correctness (see Youngberg v. Romeo 457 US 307 at 322).

**PRIVACY, EDUCATION, RESTRICTIONS AND APPEALS:**

**Privacy:**

All persons have the right to privacy, and should also have the opportunity to discuss their sexuality on a formal, informal, and private basis with anyone of their choice, provided others are willing to participate. Sexual expression and choices of partners are private and subject to the same rules of confidentiality as other matters, subject to the requirement to report incidents, alleged abuse and possible crimes in accordance with applicable laws and regulations.

**Education and Training:**

Education, training and specialized services should be available on an ongoing basis, and provided to meet each person's changing needs and changing level of understanding. Sexuality education may not be limited to biological issues. It should also include, but not be limited to:

- Relationship-building, support and assistance to couples, social skills, decision making (including whether or not to abstain from sexual contact), values clarification, dating, grooming, hygiene, sexually transmitted diseases, birth control and family planning, parenting, premarital and marital counseling, and childbirth education.

- Training in self-protection and how to avoid being exploited should be available. This should include assertiveness training, learning how to say "no", reporting abuse and exploitation, and may include self-defense training.

- Providing information regarding sexually transmitted diseases, including prevention, consent for testing, treatment, and rights to confidentiality.

Persons with disabilities who also have maladaptive sexual behavior, sexual disorders, or sexual dysfunctions should have access to appropriate treatment.

Assistance and support should be made available to persons in addressing sexuality issues with parents, guardians, family members, and other providers. This may include obtaining an advocate.

**Restrictions and Appeals:**

A parent, a legal guardian (appointed in conformance with Article 17-A of the Surrogate's Court Procedure Act or Article 81 of the Mental Hygiene Law), or a committee (appointed by the court in conformance with Article 78 of the Mental Hygiene Law), cannot limit an adult person's sexual activity. However, limitations which are in a person's best interest are permissible where the court has given the guardian or committee the authority to make such decisions. A provider of service should seek court review of such authority where it is considered that such a decision is not in a person's best interest or where it is considered that a person has the ability to make his or her own decisions. Further, those limitations which lead to the appointment of a guardian or committee may indicate the need for an evaluation of the person's ability to consent to contact.

The expression of sexuality can also be reasonably limited or restricted, including the time and location, in accordance with a plan necessary for the health and wellbeing of the individual or for effective facility management (14 NYCRR Section 633.4). If limitations or restrictions are necessary, it must be remembered that this cannot be done for disciplinary purposes, retribution, or the convenience of staff. In addition, any limitation of a person's rights must be on an individual basis, for a specific period of time, and for clinical purposes only. Objection to any part of a person's plan can be made by the person or other parties in accordance with 14 NYCRR Section 633.12, Objection to and Appeal of Care and Treatment. During the period that an objection is being reviewed or appealed, the person is to participate in programming and activities mutually agreeable to the person, the objecting party, the service provider, and the person's parent or guardian (unless the person is capable of objecting to their participation, and does so object). However, the chief executive officer of the agency/facility should enforce the recommendation of the program planning team if necessary to avoid serious harm to life or limb of the person or others.

**STAFF ISSUES**

**Additional Responsibilities:**

Intervening in a manner which preserves the dignity of the person or persons involved when sexual behavior is considered to be inappropriate.

Preventing and immediately intervening in situations which are considered to be sexual abuse.

Prohibiting the staff, volunteers, and interns of an agency/facility from any sexual contact or exploitation of any person receiving services from that agency/facility.

Ensuring, to the extent possible, that relationships between persons in facilities and anyone who is not disabled does not subject the person to exploitation. However, such relationships are not to be discouraged or prohibited unless there is a danger of exploitation.

Ensuring, to the extent possible, that staff do not project their feelings and reaction into the choices made by a person with disabilities.

**Training:**

Staff, volunteers, and interns should be provided orientation and on-going, comprehensive education, training, and instruction in human relationships, sexuality, the rights of persons with disabilities to sexual expression, and in the laws, regulations, and policies regarding consent to sexual contact, and in techniques to impart such knowledge to persons with disabilities.

Staff, volunteers, and interns should be trained to understand the difference between legal and illegal sexual activities. They should also be trained to recognize potentially harmful abusive and exploitative sexual behavior and to obtain resources to determine degree and type of intervention.

**APPLICATION TO MARRIED PERSONS:**

The principles expressed in these guidelines generally apply to persons who are married as well as to those who are not married. For persons who are married, there is the assumption that they have the ability to consent to sexual contact and, therefore, the section entitled "**SEXUAL CONTACT"** would not generally apply. However, sexual abuse is not permissible under any circumstance and appropriate action must be taken to address any such situation.

Dated: July 30, 1993

# APPENDIX 12 – OPWDD Guidance on Protocols for Interviewing Individuals Who Receive Services When Investigating Reportable Abuse and Neglect

To: Provider Associations
Voluntary Provider Agency Executive Directors
Regional Office and State Operations Directors
IBR Director

From: Megan O'Connor-Hebert, Deputy Commissioner
Division of Quality Improvement

Date: June 18, 2015

Subject: OPWDD Guidance on Protocols for Interviewing Individuals who Receive Services when Investigating Reportable Abuse and Neglect

**Effective July 1, 2015**

**Suggested distribution:**

Incident coordinators
Quality assurance/Quality improvement staff
Members of standing committees
Administrators responsible for oversight of incidents

**Background:**

In accordance with Chapter 394 of the Laws of 2014 amending Executive Law 553, the NYS Justice Center for the Protection of People with Special Needs (Justice Center) developed protocols that are to be followed when interviewing individuals receiving services during an investigation for reports of abuse or neglect. These protocols are effective July 1, 2015, and apply to all investigations of reportable incidents of abuse or neglect accepted by the Justice Center, and within the jurisdiction therein.

**Purpose:**

The purpose of this document is to provide additional guidance to providers in the OPWDD system relative to the protocols for interviewing people who receive services.

Nothing in this memorandum is to impede the Justice Center, OPWDD or a service provider's statutory obligation to conduct timely investigations of reportable incidents of abuse or neglect or to take immediate investigatory actions to ensure the safety of individuals receiving services

In addition, although the protocols are not required to be followed in criminal investigations, if a criminal investigation is conducted by Justice Center investigators, the protocols will serve as a guide for how investigators conduct interviews with individuals receiving services.

**Terms Contained Herein**

The term individual receiving services who is the **subject of the report or a potential witness** of alleged abuse/neglect is used throughout this document to mean an individual who resides in a certified residential facility, is enrolled in a certified day program or who receives any services from a state-operated provider. Notifications to meet the requirements of Chapter 394 are not required for potential witnesses who are individuals receiving services but receive only noncertified services from a voluntary provider.

In addition, a potential witness is an individual receiving services known by the service provider to be physically present in the place and at the time where the abuse/neglect is alleged to have occurred. A potential witness also includes any individual receiving services who may have information that could be useful to an investigation. Please note it is sometimes difficult to determine who may be a "potential witness" dependent upon the setting the alleged abuse/neglect is reported to have occurred in. This will be determined by the investigator.

The term **personal representative** for individuals receiving services under the age of 18 is used throughout this document to mean: a legal guardian, an actively involved spouse, a parent, an actively involved adult sibling, an actively involved adult family member, or a local commissioner of social services with custody of the person. For individuals over the age of 18, the term **personal representative** shall mean a legal guardian, an actively involved spouse, an actively involved parent, an actively involved adult child, an actively involved adult family member, and the Consumer Advisory Board for Willowbrook Class members who are fully represented.

**Notifications**

Service providers who are required to provide notifications pursuant to Mental Hygiene Law 33.23 (Jonathan's Law) must do so regardless of the notification requirements in the Justice Center Protocols for Interviewing People who Receive Services. The notifications required by Jonathan's Law satisfy this requirement. However, if no qualified person as defined in MHL 33.16 is available, then notification should be made to an available personal representative listed above.

There shall be no notification if the individual receiving services is 18 or older and does not have a personal representative, or if such parties are not reasonably available or if there is written advice that such parties do not want to be notified, or if the individual receiving services who is the subject of the report or a potential witness objects to such notification. Objections to notification of a personal representative should be reviewed on an individual basis consistent with the existing standards a service provider uses to determine the ability of a service recipient to consent to services, programs and treatment. No notification of the personal representative is to be made if providing such notification to the personal representative would compromise the investigation, violate relevant confidentiality laws, be contrary to court order, or otherwise contrary to the best interests of the alleged victim or potential witness.

The personal representative should be asked if there is additional information about the most effective ways to communicate with the service recipient to support the interview process.

If the subject of the report or the potential witness does not have a personal representative, there is no need for the service provider to comply with these requirements.

When a service provider is notified that a report of alleged abuse or neglect has been accepted by the Justice Center about a reportable incident of abuse/neglect in a program certified or operated by OPWDD, the service provider shall immediately attempt to notify the subject of the report and their personal representative that an interview may take place. "Immediately" shall mean within 24 hours for the subject of the report and 48 hours for the potential witness following the notification to the provider that an incident of reportable abuse/ neglect has been accepted into the Justice Center's Vulnerable Persons Central Register (VPCR). This notification is based on the date and time of the first report to the provider or the creation of the incident in the Incident Report and Management Application (IRMA). If this occurs after 5 p.m. on a Friday or on a state holiday, the service provider must attempt to make such notification on the next business day. If circumstances exist that do not allow such notification within the required timeframe, this shall not delay the interview of an individual receiving services who is the subject of the report. The reason will be documented on the OPWDD Form 163 Interview Protocol Notifications.

Required notifications may be completed through oral communication or in writing. All attempts to make notifications must be documented on OPWDD Form 163 Interview Protocol Notifications. A diligent effort to make such notification means that **more than one attempt** must be made. This documentation must be included as part of the investigative record which is submitted via the Web Submission of Investigation Record (WSIR).

In cases that the provider is not completing the investigation and does not have access to the investigative record, the OPWDD Form 163 is to be provided to the investigator for inclusion in the investigative record. If, the subject of the reports or potential witnesses who are individuals receiving services personal representative is not notified, the provider must document the reason on the OPWDD Form 163. As noted above, providers required to make notifications pursuant to Section 33.23 of the Mental Hygiene Law (Jonathan's Law) are not required to provide additional notification under the Justice Center Protocols for Interviewing People who Receive Services if notifications under Chapter 394 will meet the requirement for these notifications.

Providers of services must make an inquiry of the personal representative of the subject of the report and potential witnesses only the first time the personal representative is contacted to provide notification. The inquiry is to include asking the personal representative if he or she has additional information regarding the most effective ways to communicate with the individual receiving services in order to support the interview process. The inquiry and response must be documented in the record of the individual receiving services in the manner determined by the service provider.

An investigator may identify additional subjects of a report and additional potential witnesses during the course of an investigation. If this occurs, the service provider must promptly notify these individuals receiving services and their personal representatives and document using the OPWDD Form 163.

**Interviews**

An investigator must determine if an interview of an individual receiving services can be conducted in a safe and timely manner. A formal clinical assessment is not required. Factors that may be considered by an investigator include but are not limited to: ascertaining the individual's diagnosis, consulting with the licensed health professional or clinician, and/or engaging in preliminary inquiries with the individual receiving services in order to determine if the individual has the ability to provide information to assist in the investigation.

**Information from service provider**. If the investigation is not conducted by the service provider the investigator must notify the service provider if he or she will need specific information to determine whether to proceed with an interview. The information is to be supplied to the investigator within 72 hours of the service provider receiving the request.

**Exceptions**. If conducting an interview of an individual receiving services would be clinically contraindicated, the interview shall not take place unless certain circumstances exist. These circumstances include but shall not be limited to: the individual potentially possessing information relevant to maintaining the safety of individuals receiving services; possible destruction of evidence; and/or an investigator has been directed by his or her supervisor to proceed with the interview. The investigator must document in the investigative record the reason why it was appropriate to proceed with the interview.

**Communication**. If it is determined by the investigator that there may be difficulty in communication with the individual receiving services during the interview, the investigator will work with the service provider to assist the individual.

**Presence of personal representative**. If the personal representative requests to be present for an interview of an individual receiving services who is either the subject of the report or a potential witness, the personal representative may not be present for any portion of the interview that is related to specific information about the investigation which is confidential. If the individual receiving services objects to the personal representative being present during the interview or if the investigator believes the presence of the personal representative would impede the investigation, the personal representative should not be present. Further, the personal representative must not interfere with the interview. If the investigator believes that the personal representative is interfering with the interview, the investigator should stop the interview. If an investigator determines that a personal representative should not be present or should leave an interview once it is underway, the investigator must document the rationale for such decision in the investigative record.

During the introduction phase of the interview, the investigator should explain to the subject/potential witness the purpose of the investigation. This might include information such as the requirement to investigate certain situations to ensure that individuals receiving services feel safe, are able to offer information, and to help prevent future similar incidents. This introduction should also include that the information discussed will be kept confidential by the investigator.

During the closing of the interview, the investigator should explain to the subject/potential witness that the investigator has completed their interview but may need to speak to them again. This might also include informing the individual that if they remember additional information about the situation they should contact the investigator, that they should not discuss specific information with anyone other than the investigator, and to ask if they have any other questions about the process.

The Protocols for Interviewing People who Receive Services, as well as a narrated PowerPoint for investigators and administrators, are available on the Justice Center website at the following link.

http://www.justicecenter.ny.gov/media/news/justice-center-protocols-interviewing-people-who-receive-services

If you have any questions about these new procedures, contact the Incident Management Unit at Incident.Management@OPWDD.ny.gov.

C: COLT

# APPENDIX 13 - Abuse Reporting Law

§ 16.19. Confinement, care and treatment of persons with developmental disabilities

(a) No individual who is or appears to have a developmental disability shall be detained, deprived of liberty or otherwise confined without lawful authority, or inadequately, unskillfully, cruelly or unsafely cared for or supervised by any person.

(b) If the commissioner has reason to believe that a person is being detained or given inadequate, unskillful, cruel or unsafe care, as described in subdivision (a) of this section, he shall promptly investigate the matter. If, after giving the person accused of violating subdivision (a) of this section an opportunity to be heard, he finds that a violation did occur, the commissioner shall issue an order directing that person to cease and desist from continued violation.

(c) In addition to any other remedies available under this article, the commissioner may bring an action in the supreme court to enjoin any person from unlawfully subjecting a person with a developmental disability to physical, sexual, or emotional abuse, or active, passive or self neglect, or detaining a person with a developmental disability or providing inadequate, unskillful, cruel or unsafe care or supervision for such a person.

(d)(d)

(1) If, upon receiving a report that any adult thought to have a developmental disability has been subjected to physical, sexual, or emotional abuse, or active, passive or self neglect, and the commissioner has reason to believe that such adult is known by the commissioner to have received services from providers duly authorized by the commissioner and has been subjected to such abuse or neglect, the commissioner shall intervene pursuant to this section or, if such adult has not received services from said authorized providers, the commissioner shall, immediately or as soon as practicable, notify adult protective services established pursuant to section four hundred seventy-three of the social services law. The commissioner shall, within forty-eight hours, forward copies of reports made pursuant to this subdivision to the state commission of quality of care and advocacy for persons with disabilities and indicate if such report was referred to adult protective services.

(2) In order to carry out the provisions of this subdivision, the commissioner and commissioner of the office of children and family services shall develop a model memorandum of understanding which shall be entered into between each developmental disability services office and each local department of social services within its jurisdiction. Such agreement shall define the responsibilities of each developmental disability services office and social services district with respect to reports pursuant to paragraph one of this subdivision and reasonable time frames for implementing such responsibilities. Such agreement entered into in accord with such memorandum of understanding shall be finalized between all developmental disability services offices and all local departments of social services no later than ninety days after the effective date of this subdivision. A developmental disabilities services office shall be deemed a provider of services for the purposes of access to adult protective records under section four hundred seventy-three-e of the social services law.

(e) [Eff June 30, 2013] The commissioner shall promulgate rules and regulations requiring that when the office or a provider licensed, certified or operated by the office conducts an investigation regarding potential abuse, maltreatment or neglect of a person receiving services, any affected employee or volunteer shall be provided a copy of regulations and procedures governing such investigations and, in writing, notify the employee or volunteer subject of the investigation of the right and procedures for obtaining and responding to any report filed by the provider with the office in accordance with this section.

**HISTORY:**

Add, L 1983, ch 786, § 1, eff Oct 28, 1983; amd, L 1993, ch 91, § 1, eff June 7, 1993, L 2005, ch 536, §§ 1, 2, eff Feb 12, 2006 (see 2005 note below), L 2006, ch 356, §§ 1, 2, eff July 26, 2006, deemed eff on and after Feb 12, 2006 (see 2006 note below), L 2011, ch 37, § 37, eff June 1, 2011, L 2011, ch 606, § 2 (amd by L 2012, ch 501, § 1 (Part H), eff Dec 17, 2012), eff June 30, 2013 (see 2011 note below), L 2013, ch 56, § 4 (Part M), eff April 1, 2013.

**NOTES:**

Editor's Notes

Laws 2005, ch 536, § 5, eff Feb 12, 2006, provides as follows:
§ 5. The commissioner of the office of mental retardation and developmental disabilities shall promulgate any necessary rules and regulations.

Laws 2006, ch 356, § 4, eff July 26, 2006, deemed eff on and after Feb 12, 2006, provides as follows:
§ 4. The commissioner of the office of mental retardation and developmental disabilities shall promulgate any necessary rules and regulations.

Laws 2011, ch 606, § 4 (amd by L 2012, ch 501, § 1 (Part H), eff Dec 17, 2012), eff June 30, 2013, provides as follows:
§ 4. This act shall take effect June 30, 2013; provided, however, that effective immediately the commissioner of developmental disabilities and the commissioner of mental health may adopt, amend, suspend or repeal rules or regulations and take other actions prior to and in preparation for the timely implementation of this act on its effective date.

Laws 2012, ch 501, § 1, eff Dec 17, 2012, provides as follows:
Section 1. This act shall be known and may be cited as the "protection of people with special needs act".

Laws 2012, ch 501, § 2 (Part H), eff Dec 17, 2012 repealed Laws 2012, ch 6 which had amended L 2011, ch 606, § 4.

NYCRR References:

Informed consent for service plans which involve untoward risk to an individual's protection or rights when the individual is a resident of an ICF/DD.*14 NYCRR § 681.13*

Research References & Practice Aids:
65A *NY Jur 2d Hospitals and Related Health Care Facilities §§ 7, 95, 98, 217-219, 222, 238, 239, 241, 242*
66 *NY Jur 2d Infants and Other Persons Under Legal Disability § 66*
26 Am Jur Trials 97, Representing the Mentally Ill: Civil Commitment Proceedings
28 Am Jur Proof of Facts 547, Confinement to Mental Institution

Matthew Bender's New York Practice Guides:
1 *New York Practice Guide: Business and Commercial § 8.15*

Case Notes:

Conclusion that 14-year-old resident at family care home for retarded and developmentally disabled persons was physically and psychologically abused within meaning of *14 NYCRR § 87.8* was supported by evidence that operator of facility threatened to kick him, chased him until resident fell, and then stood over him and restrained him by placing his hand on resident's head until he admitted that he had not been kicked. *Jensen v Webb (1987, 3d Dept) 134 App Div 2d 713, 520 NYS2d 971.*

There was substantial evidence to support determination that resident of family care home for retarded and developmentally disabled persons was physically abused where operator of facility, by his own words, effectively "lost it" and pushed and shoved resident several times, with neither self-defense nor defense of others asserted. *Prusky v Webb (1987, 3d Dept) 134 App Div 2d 718, 520 NYS2d 975.*

# APPENDIX 14 - OPWDD-DDSO/OCFS-PSA
# Memorandum of Understanding

**OMRDD-DDSO / OCFS-PSA MEMORANDUM OF UNDERSTANDING**

## I. PURPOSE

This agreement is between_____Developmental Disabilities Services Office (DDSO) and the_____County/Local Department of Social Services (LDSS). The agreement sets forth the joint responsibilities of the DDSO and the LDSS pertaining to the abuse reporting for individuals with mental retardation or developmental disabilities. The DDSO provides services to such persons as defined in Section 1.03(22) of the Mental Hygiene Law (MHL). The LDSS through its Protective Services for Adults program (PSA) provides protective services to impaired individuals over 18years of age as defined in Article 9-B of the Social Services Law (SSL). Pursuant to Chapter 536 of the Laws of 2005, which amended Section 16.19 MHL, each DDSO and LDSS must enter into a Memorandum of Understanding (MOU) to ensure the appropriate reporting and investigation of suspected cases of abuse of adults with mental retardation or developmental disabilities.

Both entities recognize that each has a unique role in service provision to adults with mental retardation or developmental disabilities. Both entities also recognize that the needs and interests of said adults will be better served with a clear delineation of the roles and responsibilities of each entity with regard to such adults who are subjected to abuse, neglect or exploitation. Both the DDSO and the LDSS/PSA enter into this agreement in a spirit of interagency collaboration to facilitate the coordination of appropriate and necessary services to adults with mental retardation or developmental disabilities.

## II. PSA ELIGIBILITY CRITERIA AND SERVICES

All adults 18 years of age or older who meet all of the following three criteria are eligible for intervention:

1. are incapable of meeting their own basic needs or protecting themselves from harm due to mental and/or physical incapacity; and

2. are in need of protection from actual or threatened harm, neglect or hazardous conditions caused by the action or inaction of either themselves or other individuals; and

3. have no one else available who is willing and able to assist them responsibly.

Services available under PSA include counseling, locating social services, medical care and other resources in the community, advocacy, homemaker, housekeeper/chore services, money management, assistance in finding alternative living arrangements, and pursuing appropriate actions on behalf of adults with mental retardation or developmental disabilities who require involuntary intervention. These actions may include pursuing court orders to: (1) obtain access to the person in accordance with SSL 473-c; (2) provide short-term involuntary protective services in accordance with SSL 473-a; (3) request the appointment of a guardian; (4) obtain an Order of Protection under Article 8, Family Court Act.

## III. OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD) ELIGIBILITY CRITERIA AND SERVICES

OMRDD provides services to persons with diagnoses of developmental disabilities. Developmental disability is defined in Article 1, Section 1.03(22) of the Mental Hygiene Law as a disability of a person which:

1. is attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism;

2. 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; or

3. is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph; and

4. originates before such person attains age twenty-two; and

5. has continued or can be expected to continue indefinitely; and

6. constitutes a substantial handicap to such person's ability to function normally in society.

Services provided by OMRDD directly or via an authorized or certified OMRDD voluntary provider include various day and residential services, service coordination and clinical services.

## IV. REFERRAL PROCESS

### A. DDSO to LDSS/PSA

When a report of suspected abuse of an adult who may have mental retardation or developmental disabilities is made to the DDSO, the DDSO shall determine by whatever means it may have available, if OMRDD or one of its voluntary providers has, as of January 1, 2005 or later: (1) provided residential or day program services to the person; or (2) if the person has received Medicaid Service Coordination or home and community-based waiver services. If the DDSO cannot reasonably determine that such person has received services from OMRDD or one of its duly authorized providers then the DDSO shall immediately, or as soon as practicable, make a referral to LDSS/PSA of the suspected adult abuse case.

If the DDSO finds that either (1) or (2) above are met, then the DDSO or the voluntary provider shall investigate the reported case pursuant to OMRDD regulations at 14 NYCRR Part 624. If the DDSO or the voluntary provider, after making reasonable efforts, cannot gain access to the adult to investigate and/or finds that the adult needs protective services that the DDSO or voluntary provider cannot provide, then the DDSO or the voluntary provider shall make a referral to the LDSS/PSA unit responsible for Intake. The DDSO or voluntary provider will clearly state the reasons for the referral and outline the risks to the adult in his/her situation. The phone referral will be followed-up by the DDSO or voluntary provider giving LDSS/PSA any available relevant written or oral information that the DDSO or its voluntary providers may have regarding the individual's developmental and psychosocial history. The DDSO or the voluntary provider shall assist in the preparation of the affidavit establishing the factual basis for pursuing any necessary order by providing all relevant and available documentation in support that it may have as required by the County Attorney. The County Attorney that represents the LDSS/PSA shall determine if there are sufficient grounds to proceed with the order. If granted, the DDSO or the voluntary provider shallaccompany LDSS/PSA upon execution of the order. The DDSO must forward reports of the suspected adultabuse case to the Commission on Quality of Care and Advocacy for Persons with Disabilities within 48 hours of receipt and indicate if such report was referred to LDSS/PSA.

Upon receipt of a PSA referral from the DDSO, the LDSS/PSA will determine whether to accept or reject the case for a PSA assessment or request additional information as needed. If additional information is needed which is pertinent to the person's potential eligibility for PSA, the LDSS/PSA will request information from appropriate sources to enable a decision to be made as to whether the case will be accepted for a PSA assessment. In any case, a decision will be made whether to accept the case for assessment within 24 hours after the referral is received. If, on the basis of information supplied by the DDSO or voluntary provider and any additional information obtained by the LDSS/PSA, it appears that the person may be eligible for PSA, the case must be accepted for assessment.

A case will be rejected for assessment only if PSA eligibility can be conclusively ruled out. If any doubt remains about a person's PSA eligibility, the case will be accepted for assessment. LDSS/PSA will notify the DDSO or the voluntary provider of its decision to accept or reject a case immediately.

Upon acceptance of a referral for PSA assessment, the assigned LDSS/PSA caseworker will visit the referred individual within three working days of the referral (or 24 hours if the situation is life threatening) in accordance with the regulations set forth at 18 NYCRR Section 457.1 (c) (2). Either agency will perform joint visits when requested by the other agency.

## B. LDSS/PSA ASSESSMENT PROCESS

During the 60 day period between the acceptance of a referral and the determination of PSA eligibility, LDSS/PSA will assess the person's needs and provide or arrange for services, as indicated in 18 NYCRR Section 457.1 (c) to meet the needs of the person receiving services which have been identified in the assessment/investigation process.

As soon as reasonably possible, but no later than 60 calendar days after the referral date, a determination will be made whether the case will be opened for PSA beyond the assessment period. Cases which do not meet the "PSA Client Characteristics" will not be opened for ongoing PSA services (i.e. cases in which the identified risk factors have been resolved during the 60 day assessment process or cases in which there is no indication of abuse, neglect or exploitation, or the adult has a responsible person(s) or entity(ies) willing and able to meet their needs). Upon making such a decision LDSS/PSA will inform the DDSO within 7 days. For those cases which will be opened for PSA beyond the 60 day assessment period, the DDSO and LDSS/PSA will work collaboratively, as necessary, on a written case plan which outlines service goals, services to be rendered, the role of each agency and a schedule of treatment conferences including frequency, site and participants. The written case plan will be made part of the case record of each agency.

## C. PSA TO DDSO

Based upon information obtained at referral or any subsequent investigation of a suspected adult abuse case conducted by LDSS/PSA, it will refer adults with mental retardation or developmental disabilities who may need services to the appropriate DDSO. However, a referral by LDSS/PSA to a DDSO does not negate LDSS/PSA's responsibilities on behalf of persons who are eligible for PSA as specified in this agreement and in 18 NYCRR Section 457.1 (b). For those cases which require PSA involvement beyond the 60 day assessment period, within two weeks of receipt of a referral from LDSS/PSA, the DDSO and LDSS/PSA will participate in joint case management visit by both agencies with the client. The visit will be arranged and coordinated by LDSS/PSA in cooperation with the DDSO. The DDSO will, within 7 days of the joint visit or as soon as possible thereafter, advise LDSS/PSA as to whether or not the adult referred is eligible

for OMRDD services, whether or not the DDSO can provide or arrange for services to the individual, and the nature of such services to be provided.

For persons with mental retardation or developmental disabilities who are not eligible for PSA services, the DDSO will assume responsibility for providing or arranging for the provision of necessary services to these individuals. Upon receipt of a referral from LDSS/PSA, the DDSO will assess the nature and extent of the person's disabilities, their need for services, and, if found eligible by the DDSO, will plan for services that are appropriate and available.

In cases of dually diagnosed individuals (developmental disability and mental illness) in which there is uncertainty about which service system (OMRDD or OMH) has primary responsibility, OMRDD will work with the Office of Mental Health to ascertain the primary diagnosis of the adult. OMRDD will notify LDSS/PSA as to which agency (OMRDD or OMH) is assuming primary responsibility for the case.

Within 30 days of acceptance of a case by the DDSO in which LDSS/PSA will be involved beyond the 60 day assessment period, both agencies will jointly develop a written case plan which will outline service goals, services to be rendered, the specific service provider, the anticipated date services will begin, and the roles of each agency, including which agency will act as primary case manager. The primary case manager will be determined on a case by case basis, depending on the needs of the person. To the extent possible, the joint case plan shall be consistent with the PSA service plan which must be completed within 60 days of the PSA referral date in accordance with 18 NYCRR Section 457.2(b)(4). The written plan must be made part of the individual's record at each agency.

## D. SERVICE DELIVERY

In mutually served cases where both LDSS/PSA and OMRDD are involved, each agency will take responsibility for those activities assigned to them in the written case plan.

When a need is identified for placement specifically within the OMRDD system, particularly emergency placement of a person with mental retardation or developmental disabilities, the DDSO will be responsible for seeking a placement within their system.

Each agency will notify the other of significant changes in the shared case's condition or situation (e.g., changes in medical status, living situation, and loss of benefits) as soon as practicable after a change is identified.

Any activity or decision by either agency which would have the effect of discontinuing services or otherwise significantly changing the service plan must be communicated in writing to the other agency at least 30 days prior to the changes or as soon as practicable if 30 days' notification is not possible. Verbal communication may appropriately preface the written communication.

Each agency may at any point call a case conference involving both agencies and other service providers if it is felt that a conference is needed to review significant changes in the person's situation or to devise an appropriate service plan.

## V. PROCEDURES FOR INVESTIGATING ABUSE, NEGLECT OR EXPLOITATION

### A. PERSONS WHO THE DDSO REASONABLY BELIEVES HAVE MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES AND WHO HAVE RECEIVED SERVICES FROM OMRDD CERTIFIED, AUTHORIZED OR FUNDED PROGRAMS

The investigation of alleged abuse or neglect of persons receiving services while under the auspices of an OMRDD certified, authorized or funded program is the responsibility of the agency staff (the DDSO is the "agency" for state-operated programs). Requirements concerning the review and reporting of incidents of alleged abuse or neglect by OMRDD certified or authorized programs are stated in OMRDD regulations at 14 NYCRR Part 624. Agencies are also required to take such action as is necessary to protect the safety and welfare of the person receiving services and develop recommendations for protective/corrective actionsof the alleged abuse or neglect.

The agency is also responsible for intervening when abuse or neglect is suspected when the person receiving services is not under the auspices of the agency (e.g., at home) or involves people who are not affiliated with the agency. The agency may also make a referral to LDSS/PSA when the remedies of the agency are insufficient. The agency may request a joint visit with LDSS/PSA staff or other specific PSA involvement, such as assistance in obtaining a court order to access the person. LDSS/PSA will accept the referral in accordance with its standard procedures and will collaborate with the agency as needed.

### B. PERSONS WHO THE DDSO REASONABLY BELIEVES DO NOT HAVE MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES

In the event that a report is made to the DDSO or to one of its voluntary providers alleging abuse, neglect or exploitation concerning such a person, the DDSO or the voluntary provider shall make a referral to LDSS/PSA. The DDSO or the voluntary provider shall provide any relevant information it may have available regarding the person's developmental and psychosocial history to LDSS/PSA. LDSS/PSA will accept the referral in accordance with its standard procedures, and will assume initial responsibility for the investigation of such reports and intervention in the situation.

If during the investigation of the referral, LDSS/PSA becomes aware that the person may have a developmental disability and that resolution of the abuse may be facilitated by the provision of services through OMRDD, LDSS/PSA may make a referral to the DDSO for an eligibility determination and assessment for potential services. The DDSO will utilize its standard intake procedures upon receiving the referral. Either agency will perform joint visits when requested by the other agency.

### C. HIGH RISK CASES

The following protocol will be followed by the DDSO and LDSS/PSA in cases identified by either agency to be a high risk situation (imminent risk to the person's health, safety or stability of living arrangement).

<u>Existing Cases Being Mutually Served by LDSS/PSA/DDSO</u>

In cases already being mutually served by both agencies, the agency which first identifies the high risk situation will immediately notify the other agency. The purpose of the notification will be to arrive at an immediate plan to address the crisis situation using the resources available to both agencies. If joint

consultation is not possible, the agency which identified the high risk situation must take action to resolve the crisis and notify the other agency after the fact.

The primary focus in high risk cases is the resolution of the crisis. When determined feasible, LDSS/PSA and the DDSO will make every effort to arrange a joint home visit as soon as possible to assess the crisis situation (within 24 hours if the situation is life threatening) but no later than three (3) working days following the identification of the situation.

If determined necessary, either agency may call an immediate case conference to devise a plan to address the crisis situation. The plan will come from the meeting and will specify services to be provided and the role of each agency.

New Cases

In new cases, the supervisor of the agency which identifies the high risk situation will notify, when possible, the supervisor of the other agency by telephone if it is felt that the assistance of the other agency is necessary and appropriate to address the situation. The referring agency will clearly explain the high risk factors in the person's situation and the need for priority attention. When determined feasible, LDSS/PSA and the DDSO will make every effort to arrange a joint home visit as soon as possible to assess and resolve the crisis situation (within 24 hours if the situation is life threatening) but no later than three (3) working days following the identification of the situation.

## D. NOTIFICATION TO LAW ENFORCEMENT

In cases of alleged abuse, neglect or exploitation in which it is suspected that a crime has been committed, both parties recognize that law enforcement must be involved and will cooperate in this process. OMRDD regulations at 14 NYCRR Sec. 624.6 (d) require that in the case of any reportable incident or allegation of abuse where a crime may have been committed, it is the responsibility of the program administrator or designee of an OMRDD operated or certified program to notify law enforcement officials. For abuse occurring in the community in which it is suspected that a crime has been committed, a referral must be made to law enforcement. Additionally, the LDSS/PSA is mandated to report to law enforcement pursuant to Section 473-5 SSL when they have reason to believe a criminal offense has been committed against a client. Such notification may be made by the individual, LDSS/PSA or OMRDD/program staff, preferably through consultation of all three parties and it shall be documented in the individual's case record at each agency

## VI. INFORMATION SHARING

Both agencies agree to share that information concerning the referred or mutually served person which is necessary to develop and implement service plans, to the extent permitted by applicable laws and regulations including Title 18 NYCRR Part 357 and Section 33.13 MHL. Information may be disclosed where such disclosure is reasonably necessary to assess an individual or to provide protective services to an individual. Pursuant to Chapter 536 of the Laws of 2005, the DDSO shall be deemed a provider of services for the purposes of access to adult protective records under Section 473-e SSL.

Both agencies agree to orient their staffs concerning the implementation of this agreement. Both agencies agree to participate in training of each other's staff regarding the mission and operation of each program.

## VII. CONFLICT RESOLUTION

The DDSO and LDSS/PSA each retain responsibility for making eligibility decisions regarding their own programs and/or services and determining the type, duration and scope of services they will provide to eligible persons. However, in order to promote coordination and collaboration, each entity shall seek to resolve any conflicts in accordance with the process described below.

In cases of disagreement between the DDSO or its voluntary providers and LDSS/PSA staff about a person's eligibility for services or the appropriateness of a services plan, every effort shall be made to resolve the conflict at the staff/practitioner level. If resolution cannot be achieved at that level, supervisorystaff in each agency will confer to reach an acceptable resolution. If a dispute cannot be resolved at the supervisory level, the dispute will be referred to the administrative level at each agency (i.e., the DDSO Director or his/her designee and the Commissioner of the Local Dept. of Social Services or his/her designee)for resolution. Both parties agree to make every effort to resolve disputes through the internal conflict resolution process discussed above. If a dispute cannot be resolved by the two parties, each party reserves the right to pursue an equitable resolution of the matter, including requesting guidance from OCFS or OMRDD administrative staff.

## VIII. TERMS OF AGREEMENT

OMRDD and OCFS will review the terms of this agreement at least annually. Changes to the agreement may be made at any time by mutual consent.

Nothing in this agreement shall substitute, or represent a change in, either agency's legally mandated responsibilities.

_____ _____ _____

COMMISSIONER _____ County DATE
Department of Social Services

_____ _____

DIRECTOR OF _____ DATE
DDSO

1/24/07

# APPENDIX 15 - Medical/Immobilization Protective Stabilization (MIPS) Memorandum

This information can be found at the following link:

http://www.opwdd.ny.gov/node/961

# APPENDIX 16 – Investigation Timeline and Checklist

## TIPS AND TRICKS FOR THE TIMELY COMPLETION OF INVESTIGATIONS

***The following information is a helpful guide to be used to manage investigatory tasks in order to ensure completion within the Part 624 regulatory 30-day timeframe AND the 42 CFR 483 regulatory 5-day timeframe for ICFs***:

1. First 24 hours:
   - Case is assigned to Investigator
   - Investigator reviews all Intake Narratives within IRMA and makes initial plan/list of witnesses and documents needed
   - Check IRMA and write down all due dates
     - For ICFs- due date is 5 working days
   - Initial conference with supervisor (develops questions for interviews/strategy etc.)
   - Request appropriate documents
   - Create initial Investigatory Questions
   - Investigator documents all completed investigative tasks done thus far.
   - For Abuse/Neglect cases – complete SCR check and send Suspect Letters
   - Request Training Records for Target Staff
   - Review classifications and make any requests for re-classifications based on the 483 regulations

2. 24-48 hours:
   - Interview reporter
   - Review, upload and summarize any documents received
   - Document all completed tasks.

3. 48-72 hours:
   - Interview all other parties involved in the incident except the target. **Unless doing so would create additional harm, which should be noted in the report and supported by a licensed clinician.
   - Schedule interview/interrogations with all known targets.
     - For ICFs- schedule between day 3-5.
     - For all other investigations schedule between day 14-21 (week 3).
   - Review, upload and summarize documents received.

**4.** Day 3-5: **Timeframe applicable to ICF Investigations only**
   - Conduct the interview/interrogation of the target staff.
   - Conduct any additional interviews-request any additional documentation.
   - Contemporaneously document any and all investigative activities completed.
   - Begin developing conclusions and recommendations.

*Time frames are approximate and case by case. Always do interviews as soon as possible.

## TIPS AND TRICKS FOR THE TIMELY COMPLETION OF INVESTIGATIONS

**5.** 5th Working Day: **Timeframe applicable to ICF Investigations only**

- Investigator updates all investigatory tasks completed in OPWDD 149 – Upload all evidence.
    - At minimum, all basic info and background info completed, classification updated, People section includes Individual and Target, evidence uploaded up to date, police information updated, Summary of Evidence should include full summaries. Interviews summarized to date, Training Records summarized and Laws/Regulations.
- Any pending investigative activities should be listed.
- Check IRMA for any additional reports linked since assignment.
- Submit 5 Day/Final Report by 5th Day.
- Supervisor is to review and accept by COB on the 5th Working Day.
- Note: 5 Day Updates must be submitted every 5th working day during the life of the Investigation.

**6.** By the End of the First Week:

- Update OPWDD Form 149 with all investigative activities completed for supervisor to review. Supervisor reviews updated report. Weekly case conferences with Investigator and Supervisor should occur to ensure the investigation remains on track to be completed within 30 days.
- Check IRMA for any additional reports linked since assignment
- Document tasks that are planned
- Confirm all due dates are accurate.

**7.** WEEK 2

- Requests will be sent for any additional documents needed that are identified.
- Relevant Witnesses will be interviewed.
- Interviews will be scheduled for any additional witnesses identified.
- Unscheduled Interview/Interrogations will be scheduled for any additional Targets identified.
- Any documents received will be reviewed, uploaded and summarized.
- Update OPWDD Form 149 with all investigative activities completed for supervisor to review. Supervisor reviews updated report. Weekly case conferences with Investigator and Supervisor.
    - For ICF 5-day update: Investigator updates all investigatory tasks completed in OPWDD Form 149, upload all evidence. Each update should show progress in the case.
- Check IRMA for additional reports linked.

## TIPS AND TRICKS FOR THE TIMELY COMPLETION OF INVESTIGATIONS

**8.** WEEK 3

- Complete interview/interrogations and any remaining interviews.
- Summarize and upload all interviews/interrogations and remaining evidence.
- Update OPWDD Form 149 with all investigative activities completed, including Summary of Evidence and Conclusions (if applicable) for supervisor to review. Supervisor reviews updated report. Weekly case conferences with Investigator and Supervisor.
    - For ICF 5-day update: Investigator updates all investigatory tasks completed in OPWDD Form 149, upload all evidence. Each update should show progress in the case.
- Check IRMA for additional reports linked.

**9.** WEEK 4

- Check IRMA for additional reports linked.
- Completion and Submission of final report. Ensure there is a finding identified for targets identified. Supervisor will approve final report by day 30 unless there is an approved extension.
    - For ICFs: Ensure that there is a finding in accordance with federal regulations.
- Complete 30-day extension if there is a justified reason to do so.

***The following information is a guide for tracking and managing open investigations; including determining proper justification and follow-up on cases extending beyond the regulatory time frame:***

Suggested 30 Day Timeline Process

1. Review and Identification of Cases with the Potential to Extend Beyond 30 Days:
    a. All cases tracked on an Excel Spreadsheet with the Incident Report Date (Start date for investigation per regulations), 25th day of investigation and 30th day of investigation (due date) identified.
    b. Report Dates are pulled from IRMA and are marked as day 1 of the investigation for each case.
    c. On the 24th day of the investigation (or last business day prior to the 24th day), a notification is sent to the Investigator's Supervisor(s)/Investigator identifying that the case is reaching its 25th day of investigation. This notification will direct the Supervisor/Investigator to provide an update on the status of the investigation and advise if the case will be closed by the 30th day, or if an extension is needed.
    d. If an extension is requested, the Supervisor/Investigator is to include reasoning for why the case will be open beyond 30 days and estimated dates for completion of all remaining investigative tasks and closure of report, if applicable.
    e. If extension is due to a forbearance or law enforcement hold- the date the Justice Center or Law Enforcement department was last contacted is included in the request.

f. The spreadsheet is reviewed daily to ensure notifications are sent for all cases as they approach each 30-day interval and that responses have been received on all cases. Follow-up notifications are sent as needed.

2. Review of provided reasoning for case extending beyond 30 days:
    a. Criteria for justifiable extensions per regulations:
        i. A related investigation is being conducted by an outside entity (ex. Law Enforcement, Justice Center) and has requested the agency to delay necessary actions
        ii. Delays in obtaining necessary evidence that are beyond the control of the agency
            - Does not include obtaining documents from the agency
            - Example of acceptable reasoning: An essential witness is temporarily unavailable to provide testimony
        iii. Any other reasons approved by Management – case by case determinations

3. If criteria is met and justification is approved:
    a. An e-mail directive is sent to have the Supervisor/Investigator complete a 30-day letter/update to investigative report to indicate why the case is extending beyond 30 days. After the investigative report is updated, the notification is uploaded into IRMA, citing the approved justification for why the case is extending beyond 30 days.

4. If criteria is not met and justification is denied:
    a. Information about the delay is reviewed to determine if an acceptable justification can be used that meets the regulation criteria for a case extension
    b. If justification is denied and no acceptable justification exists, a deadline for case completion is given

5. Follow-Up and Review
    a. All cases are checked on day 31 to ensure they have been submitted/closed by day 30 if an extension was not requested. If a case remains open, a notification is sent to the Supervisor/Investigator requesting an update on the investigation, status of any remaining investigative tasks, and if an extension is needed. The same justification criteria (step 2) is reviewed at this point and the extension is either approved or denied.
    b. Approved Extensions- Checked on day 31 to ensure investigative report includes reason for extension, and that a letter has been uploaded to IRMA citing the approved justification/criteria. Extended cases will receive notifications every 25 days the case remains open. Updates for additional extensions are put into the investigative report and IRMA every 30 days to note the justified reason(s) for the investigation not being completed.

## Investigation Review Checklist

***The following information is a helpful guide to be used to manage and review investigatory tasks in order to ensure completion within the Part 624 regulatory 30-day timeframe AND the 42 CFR 483 regulatory 5-day timeframe***:

| Master Incident # | Incident Date | Individual Name | Incident Location |
|---|---|---|---|
| | | | |
| **Investigator** | **Program Name** | **Incident Type** | **Classification** |
| | | | |

| Incident Classification | Instructions | Completed |
|---|---|---|
| Introduction section includes information from the IRMA, as called in by the reporters? | Every linked incident must be reviewed in IRMA by the investigator, and added to the introduction section, if different from the primary incident. | ☐ |
| IRMA information is attached to the evidence? | Must include info in "the little blue J" in IRMA so that all allegations are listed in the Investigatory Questions | ☐ |
| The introduction section should account for all targets/allegations, which are included in the incident. | If a new target/allegation is added, then that notification to applicable agency should be listed in the introduction, along with any confirmation numbers. | ☐ |
| All allegations of any reportable incident should be set forth in an investigatory question, including any allegations related to systemic issues or Category 4 issues. | Include **all allegations,** not just what is in the short incident description. | ☐ |
| Immediate protections were implemented and documented? | Should have documentation for all protections, such as letter for administrative leave/suspension, work modification, etc. | ☐ |
| The investigatory question is in the proper format? | Include date/time/place and specific allegation—i.e. On 9/26/07 at 1:00 pm in the dining room of house C, did Direct Support Professional Mary Jones push Individual John Smith? | ☐ |
| All requests for reclassification are noted in introduction section, as well as JC response. | If an incident is improperly classified, then seek assistance from IMU to request reclassification. | ☐ |
| All allegations at ICF sites are classified appropriately according to relevant regulations (Part 624 or 42 CFR 483)? | Supervisor notified, sends request to IMU to assist with proper classification to address applicable regulations. Date of request and person notified of request documented in OPWDD 149 report. | ☐ |

## Investigation Review Checklist

| Testimonial Evidence | Instructions | Completed |
|---|---|---|
| Initial reporter interviewed? | As soon as possible | ☐ |
| Subject of the report interviewed and recorded, if he/she consents? | Within 24 hours, if possible | ☐ |
| All individuals present are interviewed and recorded if they consent? | Within the first 48 hours, if possible | ☐ |
| All staff present are interviewed and recorded? | Within the first 5 working days, if possible | ☐ |
| Family/Visitors/others interviewed? | | ☐ |
| Authority on the incident (MD, psych, etc.) interviewed? | | ☐ |
| Interrogation of targets completed? | | ☐ |
| Any witnesses not interviewed are explained? | Include a summary of evidence which identifies witnesses (one for staff and one for individuals). If someone is not interviewed,report MUST indicate why. | ☐ |
| All interview recordings/statements are attached? | | ☐ |
| **Demonstrative/Physical/Documentary Evidence** | **Instructions** | **Completed** |
| CFA/BSP/IPOP/Life Plan attached? | Must be included in every report | ☐ |
| Other relevant plans attached (nursing, supervision, Functional Behavioral Analysis, etc.)? | Please include all relevant plans, which will depend on the nature of the allegation. | ☐ |
| Body Check attached? | If relevant for allegation | ☐ |
| Floor plan attached, as appropriate? | Most cases should include this. | ☐ |
| Photographs and photo log attached? | If no photo log, please include a recommendation for retraining. | ☐ |
| Diagrams drawn by staff/individuals attached? | Please establish where the witnesses are. | ☐ |
| Physical evidence secured using evidence form? | | ☐ |
| Assignment sheet/schedule attached? | How were staff's assignments/duties determined? | ☐ |
| Sign in sign out sheet attached? | Please include this for all cases | ☐ |
| Any daily or behavior notes attached? | Be sure to include prior notes so that trends can be reviewed. | ☐ |
| Any Medical/hospital records attached? | If individual went to hospital, need records. | ☐ |
| Enhanced supervision sheets are reviewed and attached? | | ☐ |
| Other relevant documentation included? | 147, bed checks, well-being checks, phone logs, vehicle logs, visitor logs, community outing forms, minor event logs, physician orders, intervention paperwork, time out paperwork, medication administration records, etc. | ☐ |

## Investigation Review Checklist

| Trainings/Applicable Policies | Instructions | Completed |
|---|---|---|
| Applicable Policies are attached? | Include policies that are relevant to the allegation and any ancillary issues | ☐ |
| Training records for staff are attached? | Include training records for anything relevant to the issue. | ☐ |
| Training curriculums or statements from staff development attached? | Must be able to prove what staff were taught, so just a list is not always enough. | ☐ |
| Signed Justice Center Code of Conduct is attached for the Target(s)? | If the case is substantiated/founded, this becomes an important piece of evidence. | ☐ |
| **Summary of Evidence** | **Instructions** | **Completed** |
| Summaries of Evidence are separate and numbered? Include a summary of evidence which explains how the investigator identified witnesses | If someone is not interviewed, pleaseindicate why. | ☐ |
| All relevant evidence including testimony, documents, etc. is reflected in the summary of evidence. | Summary must include relevant information, including contributing factors and ancillary issues. | ☐ |
| The root causes and contributing factors of the incident were identified and explored during the course of the investigation and set forth in the summary of evidence. | Factors that contributed to the occurrence. For example, did the staff person work excessive overtime, was adequate training and supervision provided, was there an environmental feature that contributed. The identification of contributing factors could identify trends or systemic issues. | ☐ |
| Any ancillary issues were identified and followed up on in conclusions and recommendations | This relates to other issues that come up that may not rise to a new allegation or incident, but still should be addressed. Or maybe, a question should be asked to determine if this is a new allegation. | ☐ |
| **Conclusions** | **Instructions** | **Completed** |
| Conclusions are separate and numbered? | | ☐ |
| Conclusions are based on information found in the summary of evidence? | | ☐ |
| Any contributing factors are identified in the conclusions? | See info above in summary of evidence (root causes and contributing factors). | ☐ |
| All ancillary issues are addressed in the conclusions? | The conclusion should address all the loose ends that come up in the investigation. | ☐ |
| Any discrepancies in the evidence have been resolved to the extent possible? | Do not ignore anything. For example, if the notes are inconsistent with testimony, this should be addressed in the investigation and conclusions. If one staff person provides different details then another, try to resolve the discrepancy (keep in mind different people see different things for a multitude of reasons). | ☐ |

## Investigation Review Checklist

| Conclusions | Instructions | Completed |
|---|---|---|
| The source of the information in the conclusion is cited in the conclusion? | The supporting evidence for a given conclusion is cited within its related conclusion. I.e. "According to the Behavior Support Plan…" or "…This information is based on the Behavior Support Plan." | ☐ |
| There is a conclusion that indicates the finding of the allegation for every investigatory question, including any systemic or Category 4 findings. | Every Investigatory Question should have a conclusion with a finding AND cite the 42 CFR 483 regulation where applicable. | ☐ |
| The finding is supported by information founded in the summary of evidence. | | ☐ |
| **Recommendations** | **Instructions** | **Completed** |
| All recommendations are separated and numbered? | | ☐ |
| Each issue identified in the conclusions is addressed with a recommendation? | | ☐ |
| The recommendations include who specifically will be responsible for addressing each recommendation? | "It is recommended that the Treatment Team Leader determine…" or "It is recommended that the CEO, in conjunction with the Psychologist determine…" | ☐ |
| Was the investigative report completed within the required timeframe? If not, was a valid reason for the delay indicated? | Ex. "Due to the target staff being out on sick leave, the interrogation could not be scheduled until (date) and caused the investigation to remain open beyond the regulatory timeframe." | ☐ |

**Final Review**

| Date: | Investigator: |
|---|---|
| Date: | Reviewing Investigator: |
| ***Additional follow up needed prior to submission to Reviewing Investigator***: | |

# APPENDIX 17 – Assistance with requesting Medical Records - NEW

NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

# Memorandum

**To:** **Developmental Disabilities State Operations Office Directors**
**Executive Directors of Voluntary Provider Agencies**
**Executive Directors of Care Coordination Organizations**

**From:** **OPWDD's Statewide Committee on Incident Review**
**Megan O'Connor-Hebert, Deputy Commissioner, Division of Quality Improvement**

**Date:** **December 1, 2022**

**Re:** **Assistance with Requesting Medical Records**

**Purpose:**

Medical records include information that may be useful to agencies when investigating the death and/or mistreatment of an individual. OPWDD's Statewide Committee on Incident Review (SCIR) has been made aware that agencies are encountering difficulties obtaining medical records. The purpose of this memorandum is to assist agencies with timely access to records by reinforcing that New York State law requires that a hospital, coroner, coroner's physician or medical examiner provide copies of medical records to the Commissioner, or designee, upon written request. The following statutes authorize the Commissioner, or designee, to request such records:

**New York State Law**

Mental Hygiene Law 13.09(c) states:

*The Commissioner and directors of office facilities may request, and upon such, request the coroner, coroner's physician or medical examiner shall provide to such persons, access to original autopsy slides, tissue material and specimens derived from any autopsy or inquiry with respect to the death of a patient or resident in a mental hygiene facility, as defined in subdivision two of section five hundred fifty of the Executive Law. Such original materials shall be preserved intact, except for unavoidable changes due to necessary scientific testing and shall be returned to the coroner, coroner's physician or medical examiner.*

Mental Hygiene Law 16.01(c) states:

*(1) Notwithstanding any other provision of law, the Commissioner, or designee, may require from any hospital, as defined under article twenty-eight of the Public Health Law, any information, report, or record necessary for the purpose of carrying out the functions, powers and duties of the Commissioner related to the investigation of deaths and complaints of abuse, mistreatment, or neglect concerning persons with developmental disabilities who receive services, or had prior to death received services, in a facility as defined in section 1.03 of this chapter, or are receiving Medicaid Waiver services from the Office for People With Developmental Disabilities in a non-certified setting, and have been treated at such hospitals.*

*(2) Any information, report, or record requested by the Commissioner or designee pursuant to this subdivision shall be limited to that information that the Commissioner determines necessary for the completion of this investigation."*

County Law 677 (7) (a) states:

*"Upon the written request of the Commissioner of Mental Health, the Commissioner of the Office for People With Developmental Disabilities, the Director of the Mental Hygiene Legal Service, the Executive Director of the Justice Center for the Protection of People with Special Deeds or the director of a mental hygiene facility, as defined* in subdivision two of section five hundred fifty of the Executive Law*, at which the deceased was a patient or resident, the coroner, coroner's physician or medical examiner shall provide such person with a copy of all reports and records, including, but not limited to, autopsy reports and toxicological reports related to the deceased prepared by a person, partnership, corporation or governmental agency pursuant to any agreement or contract with the coroner or medical examiner with respect to the death of a patient or resident receiving services at such a mental hygiene facility.*

Providers who experience difficulty in obtaining medical and hospital records necessary to allow providers to investigate incidents involving individuals in their care may reach out to OPWDD to request assistance. The Commissioner, or designee, may send a letter directly to the facility/organization asking the facility/organization to send such records directly to the provider.

Requests for assistance obtaining records need to be sent by email to OPWDD's Investigation Review Team within the Incident Management Unit at cof.deathreview@opwdd.ny.gov. Providers may also contact the Investigation Review Team, by telephone at 518-473-7032 if there are any questions related to the content of this memorandum.

Thank you.