CARROLL COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Procedure Reference:

ADDRESSING MAJOR UNUSUAL INCIDENTS AND UNUSUAL INCIDENTS

TO ENSURE HEALTH, WELFARE, AND CONTINUOUS QUALITY IMPROVEMENT

Ohio Revised Code (ORC) Citations:

1.14, 149.43, 167, 313.12, 2151.03, 2151.031, 2151.421, 2901.01, 2903.16, 2907, 2907.01, 2911, 2913, 5123.19, 5123.51, 5123.61, 5123.613, 5123.62, 5126, 5126.044, 5126.058, 5126.221, 5126.25, 5126.281, 5126.31, and 5126.33

Ohio Administrative Code (OAC) Citations:

5123:2-1-02, 5123:2-2-01, 5123:2-5-07, 5123:2-7-01, 5123:2-17-01, and 5123:2-17-02

Code of Federal Regulations (CFR) Citations:

42 CFR 483.420 and 42 CFR 483.430

I. PURPOSE

This procedure establishes the requirements for addressing major unusual incidents and unusual incidents in accordance with OAC 5123:2-17-02 and MEORC- MUI and County Board policy , and implements a continuous quality improvement process in order to prevent or reduce the risk of harm to individuals.

II. APPLICATION

This procedure shall apply to county boards, councils of government, developmental centers, and all providers that contract with county boards to provide specialized services and that are subject to regulation by the Ohio Department of Developmental Disabilities regardless of payment source. Information contained in this policy does not relieve any person of the responsibility to comply with section 5123.61 of the Ohio Revised Code, which requires the reporting of abuse, neglect, or other major unusual incidents.

III. DEFINITIONS

A. **"Abuser Registry"** means the registry that was established by Ohio law to prohibit people from working with individuals if they have committed acts of abuse, neglect, misappropriation, failure to report and/or prohibited sexual relations which meet the criteria for placement on the Ohio Department of Developmental Disabilities Abuser Registry. Further information is included in Section XX of this procedure.

B. **"Administrative Investigation"** means the gathering and analysis of information related to a major unusual incident so that appropriate action can be taken to address any harm or risk of harm, and prevent recurrence.

1. There are three administrative investigation procedures that correspond with the three major unusual incident categories delineated in the definition section of this procedure:

a. *Category A* – for allegations of accidental or suspicious death, exploitation, failure to report, misappropriation, neglect, peer-to-peer act, physical abuse, prohibited sexual relations, rights code violation, sexual abuse, and verbal abuse. Further information regarding Category A investigation procedures is included in Appendix A of this procedure;

b. *Category B* – for allegations of attempted suicide, death other than accidental or suspicious death, medical emergency, missing individual, and significant injury. Further information regarding Category B investigation procedures is included in Appendix B of this procedure; and

c. *Category C* – for allegations of law enforcement involvement, unapproved behavior support, and unscheduled hospitalization. Further information regarding Category C investigation procedures is included in Appendix C of this procedure.

C. **"Agency Provider"** means a provider certified or licensed by the Ohio Department of Developmental Disabilities (DODD), or a provider approved by the Ohio Department of Medicaid (ODM) to provide services under the Transitions Developmental Disabilities Waiver (TDD), that employs staff to deliver services to individuals and who may subcontract the delivery or services. "Agency provider" also includes a county board while providing specialized services.

D. **"At-Risk Individual"** means an individual whose health and/or welfare is adversely affected or whose health and/or welfare may reasonably be considered to be in danger of being adversely affected.

E. **"County Board"** means a county board of developmental disabilities as established under Chapter 5126 of the Ohio Revised Code and/or a regional council of governments as established under Chapter 167 of the ORC when it includes at least one county board.

F. **"Department"** means the Ohio Department of Developmental Disabilities and referred to as "**DODD"** in this procedure**.**

G. **"Developmental Center"** means an intermediate care facility under the managing responsibility of the Department.

H. **"Developmental Disabilities Employee"** means any of the following:

1. An employee of DODD;

2. An employee of a county board;

3. An employee of an agency provider in a position that includes providing specialized services to an individual; or

4. An independent provider.

I. **"Incident Report"** means documentation that contains details about a major unusual incident or an unusual incident, and shall include, but is not limited to:

1. Individual's name;

2. Individual's address;

3. Date of incident;

4. Time of incident;

5. Location of incident;

6. Description of incident;

7. Type and location of injuries;

8. Immediate actions taken to ensure health and welfare of individual involved and any at-risk individuals;

9. Name(s) of Primary Person(s) Involved (PPI) and his/her relationship to the individual;

10. Name(s) of witness(es);

11. Name of agency/independent provider who was providing services at the time of the incident;

12. Statement(s) completed by person(s) who witnessed or have personal knowledge of the incident;

13. Notifications with name, title, and time and date of notice;

14. Further medical follow up;

15. Name, signature, and title of person completing the incident report;

16. Cause and contributing factors;

17. Follow up information; and

18. Prevention Plan.

J. **"Incident Tracking System (ITS)"** means DODD's web-based system for reporting major unusual incidents.

K. **"Independent Provider"** means a self-employed person who provides services for which he/she must be certified under OAC 5123:2-2-01 or a self-employed person approved by the Ohio Department of Medicaid to provide services under the Transitions Developmental Disabilities Waiver (TDD) and does not employ, either directly or through contract, any other person to provide the services.

L. **"Individual"** means a person with a developmental disability.

M. **"Individual Served"** means an individual who receives specialized services.

N. **"Intermediate Care Facility (ICF)"** means an intermediate care facility for individuals with intellectual disabilities as defined in OAC 5123:2-7-01.

O. **"Investigative Agent"** means an employee of a county board or a person under contract with a county board who is certified by DODD to conduct administrative investigations of major unusual incidents.

P. **"Mid-East Ohio Regional Council (MEORC)"** means a regional council of governments as established under ORC 167 who is under contract to provide services to the county board and functions as a part of the county board when providing said services.

Q. **"Major Unusual Incident (MUI)"** means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health and/or welfare of an individual may be adversely affected, or an individual may be placed at a likely risk of harm, if such individual is receiving services through the developmental disabilities services delivery system, or will be receiving such services as a result of the incident. There are three categories of major unusual incidents (MUIs) that correspond to the three administrative investigation procedures delineated in Appendix A, Appendix, B, and Appendix C of this procedure:

1. ***Category A***

   a. **"Accidental or Suspicious Death"** means the death of an individual resulting from an accident or suspicious circumstances;

   b. **"Exploitation"** means the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit, and/or gain;

   c. **"Failure to Report"** means that a person, who is required to report pursuant to ORC 5123.61, has reason to believe that an individual has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse, misappropriation, or exploitation that results in a risk to health and welfare or neglect of that individual, and such person does not immediately report such information to a law enforcement agency, a county board, or, in the case of an individual living in a developmental center, either to law enforcement or DODD. Pursuant to ORC 5123.61 (C) (1), such report shall be made to DODD and the county board when the incident involves an act or omission of an employee of a county board. Further information is contained in Section XIX of this procedure;

d. **"Misappropriation"** means depriving, defrauding, or otherwise obtaining the real or personal property of an individual by any means prohibited by the ORC, including ORC Chapters 2911 and 2913;

e. **"Neglect"** means when there is a duty to do so, failing to provide an individual with any treatment, care, goods, supervision, or services necessary to maintain the health and/or welfare of the individual;

f. **"Peer-to–Peer Act"** means one of the following incidents involving two individuals served:

   i. **"Peer-to-Peer Exploitation"** means the unlawful or improper act of using an individual or an individual's resources for monetary or person benefit, profit, or gain;

   ii. **"Peer-to-Peer Theft"** means intentionally depriving another individual or real or personal property valued at twenty dollars ($20) or more, or property of significant personal value to the individual;

   iii. **"Peer-to-Peer Physical Act"** means an individual is targeting, or firmly fixed, on another individual such that the act is not accidental or random, and the act results in an injury that is treated by a physician, physician assistant, or nurse practitioner. Allegations of one individual choking another, or any head or neck injuries such as a bloody nose, a bloody lip, a black eye or other injury to the eye, shall be considered major unusual incidents. Minor injuries such as scratches or reddened areas not involving the head or neck shall be considered unusual incidents and shall require immediate action, a review to uncover possible cause/contributing factors, and prevention measures;

   iv. **"Peer-to-Peer Sexual Act"** means sexual conduct and/or contact for the purposes of sexual gratification without the consent of the other individual;

   v. **"Peer-to-Peer Verbal Act"** means the use of words, gestures, or other communicative methods to purposefully threaten, coerce, or intimidate the other individual when there is the opportunity and ability to carry out the threat.

g. **"Physical Abuse"** means the use of physical force that can reasonably be expected to result in physical harm or serious physical harm as those terms are defined in ORC 2901.01. Such force may include, but is not limited to, hitting, slapping, pushing, or throwing objects at an individual.

h. **"Prohibited Sexual Relations"** means a developmental disabilities employee engaging in consensual sexual conduct, or having consensual sexual contact with an individual who is not the employee's spouse, and for whom the developmental disabilities employee was employed or under contract to provide care or supervise the provision of care at the time of the incident.

i. **"Rights Code Violation"** means any violation of the rights enumerated in ORC 5123.62 that creates a likely risk of harm to the health and/or welfare of an individual.

j. **"Sexual Abuse"** means unlawful sexual conduct or sexual contact as those terms are defined in ORC 2907.01 and the commission of any act prohibited by ORC 2907 (e.g. public indecency, importuning, and voyeurism).

k. **"Verbal Abuse"** means the use of words, gestures or other communicative methods to purposefully threaten, coerce, intimidate, harass, and/or humiliate an individual.

2. ***Category B***

a. **"Attempted Suicide"** means a physical attempt by an individual that results in emergency room treatment, in-patient observation, or hospital admission.

b. **"Death Other Than Accidental or Suspicious Death"** means the death of an individual by natural cause without suspicious circumstances.

c. **"Medical Emergency"** means an incident where emergency medical intervention is required to save an individual's life (e.g. choking relief techniques such as back blows, abdominal thrusts, cardiopulmonary resuscitation, epinephrine auto injector (Epipen) usage, or intravenous administration of fluids for dehydration).

d. **"Missing Individual"** means an incident that is not considered neglect and an individual's whereabouts, after immediate measures taken, are unknown and the individual is believed to be at risk, or pose an imminent risk of harm to self or others. An incident when an individual's whereabouts are unknown for longer than the period of time specified in the individual service plan that does not result in an imminent risk of harm to self or others shall be investigated as an unusual incident.

e. **"Significant Injury"** means an injury of known or unknown cause that is not considered abuse or neglect, and that results in concussion, broken bone, dislocation, second or third degree burns, or that requires immobilization, casting or five or more sutures. Significant injuries shall be designated in the ITS as either "known" or "unknown" cause.

3. ***Category C***

a. **"Law Enforcement"** means any incident that results in the individual served being arrested, charged or incarcerated.

b. **"Unapproved Behavior Support"** means the use of an aversive strategy or intervention prohibited by OAC 5123:2-1-02 (J) or an aversive strategy implemented without approval by the Human Rights Committee or Behavior Support Committee or without informed consent, that results in a likely risk to the individual's health and welfare. An aversive strategy or intervention prohibited by OAC 5123:2-1-02 (J) that does not pose a likely risk to health and welfare shall be investigated as an unusual incident.

c. **"Unscheduled Hospitalization"** means any hospital admission that is not scheduled unless the hospital admission is due to a pre-existing condition that is specified in the individual service plan indicating the specific symptoms and criteria that require hospitalization.

R. **"Ohio Administrative Code (OAC)"** means rules passed by the various State of Ohio administrative agencies.

S. **"Ohio Department of Medicaid Services (ODM)"** means the entity within the State of Ohio who is responsible for administering the Medicaid Program.

T. **"Ohio Revised Code (ORC)"** means statues/laws passed by the legislature of the State of Ohio.

U. **"Primary Person Involved (PPI)"** means the person alleged to have committed, or to have been responsible for, the accidental or suspicious death, exploitation, failure to report, misappropriation, neglect, physical abuse, prohibited sexual relations, rights code violation, sexual abuse, and/or verbal abuse.

V. **"Provider"** means an agency provider or independent provider that provides specialized services.

W. **"Qualified Intellectual Disability Professional (QIDP)"** means the professional who has the responsibility to coordinate implementation of individual-based habilitation programming and act as chairperson of interdisciplinary team meetings in order to coordinate comprehensive delivery of services to individuals who have intellectual disabilities and/or developmental disabilities. This term has the same meaning as in 42 CFR 483.430 (October 1, 2012).

X. **"Specialized Services"** means any program or service designed and operated to serve primarily individual, including a program or service provided by an entity licensed or certified by the Ohio Department of Developmental Disabilities.

Y. **"Unusual Incident (UI)"** means an event or occurrence involving an individual that is not consistent with routine operations, policies and procedures, or the individual's care or individual service plan, but is not a major unusual incident (MUI). Unusual incident includes, but is not limited to:

1. Dental injury;
2. Falls;
3. An injury that is not a significant injury; Medication errors without a likely risk to health and/or welfare;
4. Overnight relocation of an individual due to a fire, natural disaster, or mechanical failure;
5. An incident involving two individuals served that is not a Peer-to-Peer Act major unusual incident; and
6. Rights Code Violations or Unapproved Behavior Support without a likely risk to health and/or welfare.

Z. **"Working Day"** means Monday, Tuesday, Wednesday, Thursday, or Friday, except when that day is a holiday as defined in ORC 1.14.

IV. REPORTING REQUIREMENTS

A. Reports regarding all major unusual incidents involving an individual who resides in an intermediate care facility or who receives round-the-clock waiver services shall be filed and the requirements of this rule followed regardless of where the incident occurred.

B. Reports regarding the following major unusual incidents shall be filed and the requirements of this rule followed regardless of where the incident occurred:

1. Accidental or suspicious death;
2. Attempted suicide;
3. Death other than accidental or suspicious death;

4. Exploitation;

5. Failure to report;

6. Law enforcement;

7. Misappropriation;

8. Missing individual;

9. Neglect;

10. Peer-to-peer act;

11. Physical abuse;

12. Prohibited sexual relations;

13. Sexual abuse; and

14. Verbal abuse.

C. Reports regarding the following major unusual incidents shall be filed and the requirements of this rule followed only when the incident occurs in a program operated by a county board or when the individual is being served by a licensed or certified provider:

1. Medical emergency;

2. Rights code violation;

3. Significant injury;

4. Unapproved behavior support; and

5. Unscheduled hospitalization.

D. Immediately upon identification or notification of a major unusual incident, the provider shall take all reasonable measures to ensure the health and welfare of at-risk individuals. The provider and county board shall discuss any disagreements regarding reasonable measures in order to resolve the issues. If the county board and provider are unable to agree on reasonable measures to ensure the health and welfare of at-risk individuals, DODD shall make the determination. Such measures shall include:

1. Immediate and ongoing medical attention, as appropriate;

2. Removal of an employee from direct contact with any at-risk individual when the employee is alleged to have been involved in abuse or neglect until such time as the provider has reasonably determined that such removal is no longer necessary' and

3. Other necessary measures to protect the health and welfare of at-risk individuals.

E. Immediately upon receipt of a report or notification of an allegation, the county board shall:

1. Ensure that all reasonable measures necessary to protect the health and welfare of at-risk individuals have been taken;

2. Determine if additional measures are needed; and

3. Notify DODD if circumstances in section IX (A) of this procedure that requires a DODD-directed administrative investigation are present. Such notification shall take place on the first working day the county board becomes aware of the incident.

F. The provider shall immediately, but no later than four hours after the discovery of the incident, notify the county board through means identified by the county board of the following incidents or allegations (please refer to Appendix D of this procedure)

1. Accidental or suspicious death;

2. Exploitation;

3. Misappropriation;

4. Neglect;

5. Peer-to-peer act;

6. Physical abuse;

7. Sexual abuse;

8. Verbal abuse; and

9. When the provider has received an inquiry from the media regarding a major unusual incident.

G. For all major unusual incidents, all providers shall submit a written incident report to the county board contact or designee no later than three p.m. (3:00 p.m.) the next working day following initial knowledge of a potential or determined major unusual incident. The report shall be submitted in a format prescribed by DODD.

H. MEORC shall enter preliminary information regarding the incident in the ITS, and in the manner prescribed by DODD by three p.m. (3:00 p.m.) on the working day following notification by the provider or of becoming aware of the major unusual incident.

I. When a provider has placed an employee on leave or otherwise taken protective action pending the outcome of the administrative investigation, the county board or DODD, as applicable, shall keep the

provider apprised of the status of the investigation, so that the provider can resume normal operations as soon as possible consistent with the health and welfare of at-risk individuals. The provider shall notify the county board or DODD, as applicable, of any changes regarding the protective action.

J. If the provider is a developmental center, all reports required by this procedure shall be made directly to DODD.

K. The county board shall have a system that is available twenty-four (24) hours a day, seven (7) days per week, to receive and respond to all reports required by this rule. The county board shall communicate this system in writing to all providers in the county and to the department (please refer to Appendix D of this procedure).

V. REPORTING OF ALLEGED CRIMINAL ACTS

A. Nothing in this rule relieves mandatory reporters of the responsibility to immediately report to the intermediate care facility administrator or administrator designee allegations of mistreatment, neglect, or abuse and injuries of unknown source when the source of the injury was not witnessed by any person, and the source of the injury could not be explained by the individuals, and the injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidences of injuries over time pursuant to 42 CFR 483.420 (October 1, 2012).

B. The provider shall immediately report to the law enforcement entity having jurisdiction of the location where the incident occurred, any allegation of exploitation, failure to report, misappropriation, neglect, peer-to-peer act, physical abuse, sexual abuse, or verbal abuse which may constitute a criminal act. The provider shall document the time, date, and name of the person notified of the alleged criminal act. The county board shall ensure that the notification has been made.

C. DODD shall immediately report to the Ohio State Highway Patrol any allegation of exploitation, failure to report, misappropriation, neglect, peer-to-peer act, physical abuse, sexual abuse, or verbal abuse occurring at a developmental center which may constitute a criminal act. DODD shall document the time, date, and name of the person notified of the alleged criminal act.

VI. ABUSED OR NEGLECTED CHILDREN

A. All allegations of abuse or neglect as defined in ORC 2151.03 and 2151.031 of an individual under the age of twenty-one (21) years shall be immediately reported to the local public children's services agency. The notification may be made by the provider or the county board. The county board shall ensure that the notification has been made.

VII. NOTIFICATION REQUIREMENTS FOR MAJOR UNUSUAL INCIDENTS

A. The provider shall make the following notifications, as applicable, when the major unusual incident or discovery of the major unusual incident occurs when such provider has responsibility for the individual. The notification shall be made on the same day the major unusual incident or discovery of the major unusual incident occurs and include immediate actions taken:

1. Guardian or other person whom the individual has identified;

2. Service and Support Administrator;

3. Licensed of certified residential provider;

4. Staff or family living at the individual's residence who have responsibility for the individual's care; and

5. Support broker for an individual enrolled in the Self-Empowered Life Funding Waiver.

B. All notifications or efforts to notify shall be documented. The county board shall ensure that all required notifications have been made.

C. Notification shall not be made if the person to be notified is the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved.

D. Notification shall be made to the individuals, individuals' guardians, and other persons whom the individuals have identified in a peer-to-peer act unless such notification could jeopardize the health and welfare of an individual involved.

E. Notification to a person is not required when the report comes from such person or in the case of a death when the family is already aware of the death.

F. In any case where law enforcement has been notified of an alleged crime, DODD may provide notification of the incident to any other provider, developmental center, or county board for whom the primary person involved works, for the purpose of ensuring the health and welfare of any at-risk individual. The notified provider or county board shall take such steps to address the health and welfare needs of any at-risk individual and may consult DODD in this regard. DODD shall inform any notified entity as to whether the incident is substantiated. Providers, developmental centers, or county boards employing a primary person involved shall notify DODD when they are aware that the primary person involved works for another provider.

VIII. GENERAL ADMINISTRATIVE INVESTIGATION REQUIREMENTS

A. Each county board shall employ at least one investigative agent or contract with a person or governmental entity for the services of an investigative agent. An investigative agent shall be certified by DODD in accordance with OAC 5123:2-5-07. Developmental center investigators are considered certified investigative agents for the purpose of this rule.

1. The county board has entered into a contract with MEORC for provision of investigative agent services.

B. All major unusual incident require an administrative investigation meeting the applicable administrative investigation procedure in Appendix A, Appendix B, or Appendix C to this procedure unless it is not possible or relevant to the administrative investigation to meet a requirement under this procedure, in which case the reason shall be documented. Administrative investigations shall be conducted and reviewed by investigative agents.

1. DODD or the county board may elect to follow the administrative investigation procedure for Category A major unusual incidents for any major unusual incident.

2. Based on the facts discovered during administrative investigation of the major unusual incident, the category may change. If a major unusual incident changes category, the reason for the change shall be documented and the new applicable category administrative investigation procedure shall be followed to investigate the major unusual incident.

3. Major unusual incidents that involve an active criminal investigation may be closed as soon as the county board and MEORC ensure that the major unusual incident is properly coded, the history of the primary person involved has been reviewed, cause and contributing factors are determined, a finding is made, and prevention measure implemented. Information needed for closure of the major unusual incident may be obtained from the criminal investigation.

C. County board staff may assist the investigative agent by gathering documents, entering information into the ITS, fulfilling Category C administrative investigation requirements, or performing other administrative or clerical duties that are not specific to the investigative agent role.

D. Except when law enforcement or the public children's services agency is conducting the investigation, the investigative agent shall conduct all interviews for major unusual incidents, unless the investigative agent determines the need for assistance with interviewing an individual. For a major unusual incident occurring at an intermediate care facility, the investigative agent may utilize interviews conducted by the intermediate care facility, or conduct his/her own interviews. If the investigative agent determines the information is reliable, the investigative agent may utilize other information received from law enforcement, the public children's services agency, or providers in order to meet the requirements of this procedure.

E. Except when law enforcement or the public children's services agency has been notified, and is considering conducting an investigation, MEORC shall commence an administrative investigation. If law enforcement or the public children's services agency notifies the county board that it has declined to investigate, MEORC shall commence the administrative investigation within a reasonable amount of time based on the initial information received or obtained and consistent with the health and welfare of all at-risk individuals, but no later than twenty four (24) hours for a major unusual incident in Category A or not later than three (3) working days for a major unusual incident in Category B or Category C.

F. An intermediate care facility shall conduct an investigation that complies with applicable federal regulations, including CFR 483.420 (October 1, 2012), for any unusual incident or major unusual incident involving a resident of the intermediate care facility, regardless of where the unusual incident or major unusual incident occurs. The intermediate care facility shall provide a copy of its full report of an administrative investigation of a major unusual incident to the county board/MEORC. The investigative agent may utilize information

from the intermediate care facility's administrative investigation to meet the requirements of this procedure, or conduct a separate administrative investigation. The county board/MEORC shall provide a copy of its full report of the administrative investigation to the intermediate care facility. DODD shall resolve any conflicts that arise.

G. When an agency provider, excluding an intermediate care facility, conducts an internal review of an incident for which a major unusual incident has been filed, the agency provider shall submit the results of its internal review of the incident, including statements and documents, to the county board/MEORC within fourteen (14) calendar days of the agency becoming aware of the incident.

H. All developmental disabilities shall cooperate with administrative investigations conducted by entities authorized to conduct investigations. Providers and county boards shall respond to requests for information within the time frame requested. The time frames identified shall be reasonable.

I. The investigative agent shall complete a report of the administrative investigation and submit it for closure in the ITS within thirty (30) working days unless the county board (MEORC) requests and DODD grants an extension for good cause. If an extension is granted, DODD may require submission of interim reports, and may identify alternative actions to assist with the timely conclusion of the report.

J. The report shall follow the format prescribed by DODD. The investigative agent shall include the initial allegation, a list of persons interviewed and documents reviewed, a summary of each interview and document reviewed, and a findings and conclusions section which shall include the cause and contributing factors to the incident and the facts that support the finds and conclusions.

IX. DEPARTMENT-DIRECTED ADMINISTRATIVE INVESTIGATIONS OF MAJOR UNUSUAL INCIDENTS

A. DODD shall conduct the administrative investigation when the major unusual incident incldes an allegation against:

1. The superintendent of a county board or developmental center;

2. The executive director or equivalent of a regional council of governments;

3. A management employee who reports directly to the superintendent of the county board, the superintendent of a developmental center, or executive director or equivalent of a regional council of governments;

4. An investigative agent;

5. A service and support administrator;

6. A major unusual incident contact or designee employed by a county board;

7. A current member of a county board;

8. A person having any known relationship with any of the persons specified in paragraphs IX (A) (1) to IX (A) (8) of this procedure when such relationship may present a conflict of interest or the appearance of a conflict of interest; or

9. An employee of a county board when it is alleged that the employee is responsible for an individual's death, has committed sexual abuse, engage in prohibited sexual activity, or committed physical abuse or neglect resulting in emergency room treatment or hospitalization.

B. A DODD-directed administrative investigation or administrative investigation review may be conducted following the receipt of a request from a county board, developmental center, provider, individual, or guardian if DODD determines there is a reasonable basis for the request.

C. DODD may conduct a review or administrative investigation of any major unusual incident or may request that a review or administrative investigation be conducted by another county board, a regional council of governments, or any other governmental entity authorized to conduct an investigation.

X. WRITTEN SUMMARIES OF MAJOR UNUSUAL INCIDENTS

A. No later than five (5) working days following the posting of the closure recommendation on the Incident Tracking System by the county board, developmental center, or DODD, the county board, developmental center or DODD shall provide a written summary of the administrative investigation of each Category A or Category B major unusual incident, including the allegations, the facts and findings, including whether the case was substantiated or unsubstantiated, as applicable, and preventive measures implemented in response to the major unusual incident unless the information in the written summary has already been communicated, to the following parties:

1. The individual, individual's guardian, or other person whom the individual has identified, as applicable;

2. In the case of a peer-to-peer act, both individuals, individuals' guardians, or other persons whom the individuals have identified, as applicable;

3. The licensed or certified provider and provider at the time of the major unusual incident; and

4. The individual's services and support administrator and support broker, as applicable.

B. In the case of an individual's death, the written summary shall be provided to the individual's family only upon request by the individual's family.

C. The written request shall not be provided to the primary person involved, the spouse of the primary person involved, or the significant other of the primary person involved. No later than five (5) working days following the closure of a case, the county board shall make a reasonable attempt to notify the primary person involved as to whether the major unusual incident has been substantiated, unsubstantiated due to insufficient evidence, or unsubstantiated due to the allegation being unfounded.

D. If a service and support administrator is not assigned, a county board designee shall be responsible for ensuring the preventive measures are implemented based upon the written summary.

E. An individual, individual's guardian, other person whom the individual has identified, or provider may dispute the findings by submitting a letter of dispute and supporting documentation to the county board superintendent or to the director of DODD if the department conducted the administrative investigation with fifteen (15) calendar days following receipt of the findings. An individual may receive assistance from any person selected by the individual to prepare a letter of dispute and provide supporting documentation.

F. The county board superintendent or designee, or the director or designee, as applicable, shall consider the letter of dispute, the supporting documentation, and any other relevant information, and issue a determination within thirty (30) calendar days of such submission, and take action consistent with such determination, including confirming or modifying the findings or directing that more information be gathered and the findings be reconsidered.

G. In cases where the letter of dispute has been filed with the county board, the disputant may dispute the final findings made by the county board by filing those findings and any documentation contesting such findings as are disputed with the director of DODD within fifteen (15) calendar days of the county board determination. The director shall issue a decision within thirty (30) calendar days.

XI. REVIEW, PREVENTION, AND CLOSURE OF MAJOR UNUSUAL INCIDENTS

A. County boards and agency providers shall implement a written procedure for the internal review of all major unusual incidents, and shall be responsible for taking all reasonable steps necessary to prevent the recurrence of major unusual incidents.

B. The individual's team, including the county board and provider, shall collaborate on the development of preventive measures to address the causes and contributing factors to the major unusual incident. The team members shall jointly determine what constitutes reasonable steps necessary to prevent the recurrence of major unusual incidents. If there is no service and support administrator, individual team, qualified intellectual disability professional, or agency provider involved with the individual, a county board designee shall ensure that preventive measures as are reasonably possible are fully implemented.

C. DODD may review reports submitted by a county board or developmental center. DODD may obtain additional information necessary to consider the report, including copies of all administrative investigation reports that have been prepared. Such additional information shall be provided within the time period specified by DODD.

D. DODD shall review and close reports regarding the following major unusual incidents:

1. Accidental or suspicious death;

2. Exploitation;

3. Failure to report;

4. Misappropriation;

5. Missing individual;
6. Neglect;
7. Peer-to-peer act;
8. Physical abuse;
9. Prohibited sexual relations;
10. Rights code violation;
11. Sexual abuse;
12. Significant injury when cause is unknown;
13. Unapproved behavior support;
14. Verbal abuse;
15. Any major unusual incident that is the subject of a director's alert; and
16. Any major unusual incident investigated by the department.

E. The county board shall review and close reports regarding the following major unusual incidents:

1. Attempted suicide;
2. Death other than accidental or suspicious death;
3. Law enforcement;
4. Medical emergency;
5. Significant injury when cause is known; and
6. Unscheduled hospitalization.

F. DODD may review any case to ensure it has been properly closed and shall conduct sample reviews to ensure proper closure by the county board. DODD may reopen any administrative investigation that does not meet the requirements of OAC 5123:2-17-02. The county board shall provide any information deemed necessary by DODD to close the case.

G. DODD, the county board, and MEORC shall consider the following criteria when determining if a case should be closed:

1. Whether sufficient reasonable measures have been taken to ensure the health and welfare of any at-risk individual;

2. Whether a thorough administrative investigation has been conducted consistent with the standards set forth in this rule;

3. Whether the team, including the county board and provider, collaborated on developing preventive measures to address the causes and contributing factors;

4. Whether the county board has ensured that preventive measures have been implemented to prevent recurrence;

5. Whether the county board has ensured that preventive measures have been implemented to prevent recurrence;

6. Whether the incident is part of a pattern or trend as flagged through the Incident Tracking System requiring some additional action; and

7. Whether all requirements set forth in statute or rule have been satisfied.

XII. ANALYSIS OF MAJOR UNUSUAL INCIDENT TRENDS AND PATTERNS

A. Providers shall produce a semi-annual and annual report regarding major unusual incident trends and patterns which shall be sent to the county board. The county board in conjunction with MEORC shall semi-annually review providers' reports. The semi-annual review shall be cumulative for January 1st through June 30th of each year and include an in-depth analysis. The annual report shall be cumulative for January 1st through December 31st of each year and include an in-depth analysis.

B. All reviews and analyses shall be completed within thirty (30) calendar days following the end of the review period. The semi-annual and annual reports shall contain the following elements:

1. Date of review;

2. Name of person completing review;

3. Timer period of review;

4. Comparison of data for previous three (3) years;

5. Explanation of data;

6. Data or review by major unusual incident category type;

7. Specific individual involved in established trends and patterns (i.e. five (5) major unusual incidents of any kind within six months, ten (10) major unusual incidents of any kind within a year, or other pattern identified by the individual's team);

8. Specific trends by residence, region, or program;

9. Previously identified trends and patterns; and

10. Action plans and preventive measures to address noted trends and patterns.

C. The county board, in conjunction with MEORC, shall conduct the analysis and implement follow-up actions for all programs operated by the county board, such as workshops, schools, and transportation. The county board shall send its analysis and follow-up actions to DODD by August 31st of each year for the semi-annual review and by February 28th of each year for the annual review. DODD shall review the analysis to ensure that all issues have been reasonably addressed to prevent recurrence.

D. Providers shall conduct the analysis, implement follow-up actions, and send the analysis and follow-up actions to the county board/MEORC for all programs operated in the county by August 31st of each year for the semi-annual review and by February 28th of each year for the annual review. The county board, in conjunction with MEORC, shall review the analysis to ensure that all issues have been reasonably addressed to prevent recurrence. The county board/MEORC shall keep the analyses and follow-up actions on file and make these documents available to DODD upon request.

E. The county board shall ensure that trends and patterns of major unusual incidents are included and addressed in the individual service plan of each individual affected.

F. The county board, in conjunction with MEORC, shall have a stakeholder committee that reviews trend and patterns of major unusual incidents. The stakeholder committee shall be made up of a reasonable representation of the county board, providers, individuals who receive services and their families, MEORC, and other stakeholders deemed appropriate by the stakeholder committee.

1. The role of the stakeholder committee shall be to review and share the county or council of governments aggregate data prepared by the county board or council of governments to identify overall/aggregate trends, patterns, or areas for improving the quality of life for individuals served in the county;

2. The stakeholder committee shall meet to review and analyze the aggregate data for the first six (6) months of the calendar year between July 1st and September 30th of each year;

3. The stakeholder committee shall meet to review and analyze the aggregate data for the preceding calendar year between January 1st and March 31st of each year;

4. The county board, in conjunction with MEORC, shall send the aggregate data prepared for the meeting to all participants at least ten calendar days in advance of the meeting;

5. The county board, in conjunction with MEORC, shall record and maintain minutes of each meeting, distribute the minutes to stakeholder committee members, and make the minutes available to any person upon request; and

6. The county board shall ensure follow-up actions identified by the stakeholder committee have been implemented.

G. DODD shall prepare a report on trends and patterns identified through the process of reviewing major unusual incidents. DODD will periodically, but at least semi-annually, review this report with a committee appointed by the Director of DODD which shall consist of at least six (6) members who represent various stakeholder groups, including Disability Rights Ohio and the Ohio Department of Medicaid. The committee shall make recommendations to DODD regarding whether or not appropriate actions have been taken to ensure the health and welfare of individuals served. The committee may request that DODD obtain additional information as may be necessary to make recommendations.

XIII. REQUIREMENTS FOR UNUSUAL INCIDENTS

A. Unusual incidents shall be reported and investigated by the provider.

B. Each agency provider and county board as provider shall develop and implement a written unusual incident policy and procedure that:

1. Identifies what is to be reported as an unusual incident which shall include unusual incidents as defined in OAC 5123:2-17-02;

2. Requires an employee who becomes aware of an unusual incident to report it to the person designated by the agency provider or the county board as provider who can initiate the proper action;

3. Requires the report to be made no later than twenty-four (24) hours after the occurrence of the unusual incident; and

4. Requires the agency provider or the county board as provider to investigate unusual incidents, identify the cause and contributing factors when applicable, and develop preventive measures to protect the health and welfare of any at-risk individuals.

C. The county board shall ensure that all county board staff are trained and knowledgeable regarding the county board unusual incident policy and procedure, and agency providers shall ensure that all staff are trained and knowledgeable regarding agency provider unusual incident policy and procedure.

D. If the unusual incident occurs at a site operated by the county board or at a site operated by an entity with which the county board is contracting, the county board or contract entity shall notify the licensed provider or staff, guardian, or other person whom the individual has identified, as applicable, at the individual's residence. The notification shall be made on the same day the unusual incident is discovered.

E. Independent providers shall complete an incident report, notify the individual's guardian or other person whom the individual has identified, as applicable, and forward the incident report to the service and support administrator or county board designee on the same day the unusual incident is discovered.

F. Each agency provider, county board as provider, and independent provider shall review all unusual incidents as necessary, but no less than monthly, to ensure appropriate preventive measures have been implemented, and trends and patterns identified, and addressed, as appropriate.

1. The county board, in conjunction with MEORC, may also conduct a review of unusual incidents to ensure appropriate preventive measures have been implemented, and trends and patterns identified and addressed, as appropriate;

G. Unusual incident reports, documentation of identified trends and patterns, and corrective action shall be made available to the county board and DODD upon request.

H. The county board as provider, each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to, the name of the individual, a brief description of the unusual incident, any injuries, time, date, and location of the incident, preventive measures, and cause and contributing factors.

I. The agency provider, county board as provider, and county board shall ensure that trends and patterns of unusual incidents are included and addressed in the individual service plan of each individual affected.

XIV. OVERSIGHT

A. The county board, in conjunction with MEORC, shall review, on at least a quarterly basis, a representative sample of provider logs, including logs where the county board is a provider, to ensure that major unusual incidents have been reported, preventive measures have been implemented, and that trends and patterns have been identified and addressed in accordance with OAC 5123:2-17-02. The sample will be made available to DODD upon request.

B. When the county board is a provider, DODD shall review, on a monthly basis, a representative sample of county board logs to ensure that major unusual incidents have been reported, preventive measures have been implemented, and that trends and patterns have been identified and addressed in accordance with this rule. The county board shall submit the specified logs to DODD upon request.

C. DODD shall conduct reviews of county boards and providers as necessary to ensure the health and welfare of individuals and compliance with OAC 5123:2-17-2. Failure to comply with OAC 5123:2-17-02 may be considered by DODD in any regulatory capacity, including certification, licensure, and accreditation.

XV. ACCESS TO RECORDS

A. Reports made under ORC 5123.61 and OAC 5123:2-17-02 are not public records as defined in ORC 149.43. Records may be provided to parties authorized to receive such in accordance with ORC 5123.613 and ORC 5126.044 to any governmental entity authorized to investigate the circumstances of the alleged abuse, neglect, misappropriation, or exploitation, and to any party to the extent that release of a record is necessary for the health or welfare of an individual.

B. The county board, MEORC, or DODD shall not review, copy, or include in any report required by OAC 5123:2-17-02, a provider's personnel records that are confidential under state or federal statues or rules, including medical and insurance records, workers' compensation records, employment eligibility verification (I-9) forms, and social security numbers. The provider shall redact any confidential information contained in a record before copies are provided to the county board or DOODD. A provider shall make all other records available upon request by the county board or DODD.

C. Any party entitled to receive a report required by OAC 5123:2-17-02 may waive receipt of the report. Any waiver of receipt of a report shall be made in writing.

XVI. TRAINING

A. The county board and agency provider shall ensure staff employed in direct services positions are trained on the requirements of OAC 5123:2-17-02 prior to direct contact with any individual. Thereafter, staff employed in direct serves positions shall receive annual training on the requirements of OAC 5123:2-17-02, including a review of health and welfare alerts issued by DODD since the previous year's training.

B. The county board and agency providers shall ensure staff employed in positions other than direct services positions are trained on the requirements of this rule no later than ninety (90) days from the date of hire. Thereafter, staff employed in positions other than direct services positions shall receive annual training on the requirements of OAC 5123:2-17-02 including a review of health and welfare alerts issued by DODD since the previous year's training.

C. Independent providers shall be trained on the requirements of OAC 5123:2-17-02 prior to application for initial certification in accordance with OAC 5123:2-2-01 and shall receive annual training on the requirements of OAC 5123:2-17-02 including a review of health and welfare alerts issued by DODD since the previous year's training.

XVII. MID-EAST OHIO REGIONAL COUNCIL POLICY AND PROCEDURES

A. Policy and procedures developed by the Mid-East Ohio Regional Council - Major Unusual Incident Advisory Council serve as an addendum to county board policy and procedures to ensure the continuum of major unusual incident services and reporting systems coordination services.

XVIII. MEMORANDUM OF UNDERSTANDING

A. The county board shall have a Memorandum of Understanding (MOU) in place. The legal mandate for this memorandum is ORC 5126.058 which calls for mandated subscribers to enter into an MOU concerning the handling and coordinating of reports of abuse, neglect, and exploitation of individual with disabilities.

B. The MOU will assist in setting forth normal operating procedures for the reporting and investigation of reports of abuse, neglect and exploitation as described in OAC 5123:2-17-02. The MOU shall exist to assist legal professionals and organizations concerned with the health and welfare of individuals, and outline the responsibilities of the mandated reporters and cooperation required between entities.

C. The purpose of the MOU is to effectively address the need to repot and investigate reports of abuse, neglect, and exploitation, and to define the issues and concerns involved in doing so. These purposes assist the participants/subscribers to work cooperatively to achieve the following:

1. Establishment of normal operating procedures to be employed by all concerned officials in the execution of their respective responsibilities under ORC sections 313.12, 2151.421, 2903.16, 5126.058, 5126.31, and 5126.33.

2. Assurance of the prompt and proper reporting of incidents of suspected or actual abuse, neglect, and exploitation.

3. Timely and thorough investigations of abuse, neglect, and exploitation, expediting referrals in order to protect individual with developmental disabilities while eliminating unnecessary interviews of a person who is the subject of a report of abuse and/or neglect and/or exploitation.

4. Protection of the individual and family from further trauma by elimination of duplicated efforts by all professionals involved, elimination of gaps by all professionals involved, and the provision of protection, aid, and treatment.

5. Rapid prosecution and/or treatment of the perpetrators of abuse, neglect, and exploitation; and

6. Definition of the responsibilities and interrelationship among participating agencies for the handling, coordination, investigation, prosecution, and treatment, and to define responsibilities in a criminal and an administrative investigation.

D. The following parties are mandated subscribers to the MOU per ORC 5126.058:

1. The county board of developmental disabilities;

2. The probate judge or representative;

3. The county peace officer;

4. All chief municipal peace officers within the county;

5. Other law enforcement officers handling abuse, neglect, and exploitation of persons with developmental disabilities;

6. The prosecuting attorney for the county;

7. The children’s services agency; and

8. The county coroner/medical examiner.

XIX. FAILURE TO REPORT

A. Reporting requirements are set forth to ensure that mandated reporters are provided with a process for reporting allegations, suspicions, and actual occurrences of abuse, neglect, and theft. Failure to notify the appropriate entity constitutes "failure to report" by the mandated reporter.

B. Failure to report encompasses the following definitions/standards:

1. General definition:

a. Per ORC 5126.61 (C), any person considered a required/mandated reporter having reason to believe that a person with developmental disabilities has suffered, or faces a substantial risk of suffering, any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse or neglect of that person, shall immediately report the information to the specified entity.

2. Criminal standard includes three (3) categories of failure to report, all of which require notification to law enforcement:

a. When the required/mandated reporter fails to report under ORC 5126.61 (C);

b. When a physician performing services fails to report under ORC 5123.51 (E); or

c. When the superintendent or designee of a county board fails to notify law enforcement of an incident that may constitute a crime under ORC 5123.51 (G) (3).

3. Registry Standard

a. When a developmental disabilities employee unreasonably fails to make a report pursuant to ORC 5123.61 when said employee knew, or should have known, that the failure to report would result in a substantial risk of harm to an individual with developmental disabilities per ORC 5123.51 (C) (3) (a) (vii).

C. A failure to report major unusual incident is filed when one of the following elements has been met:

1. An individual has suffered a wound, injury, disability, or condition of such a nature as to reasonably indicate abuse or neglect, and a mandated reporter does not make the required report to the appropriate entity; or

2. An individual faces a substantial risk of suffering any wound, injury, disability or condition of such a nature as to reasonably indicate abuse or neglect, and a mandated reporter does not make the required report to the appropriate entity.

XX. PROVISION OF ANNUAL WRITTEN NOTICE OF DODD ABUSER REGISTRY CONDUCT

A. The county board, each contracting entity of the county board, each owner, operator, or administrator of a licensed facility as defined in ORC 5123.19, and each owner, operator, or administrator of a program certified by DODD to provide supported living shall provide developmental disabilities employees with an annual written notice, prescribed by DODD, which defines and explains the conduct that may result in placement of a developmental disabilities employee on the DODD Abuser Registry.

   1. The required notice shall include all necessary information as outlined by DODD.

B. If a developmental disabilities employee fails to receive the required notice, said notification failure does not exempt the employee from inclusion on the DODD Abuser Registry.

C. The county board shall implement the requirements of ORC 5123.19 in a manner which demonstrates that each of its developmental disabilities employees has received the required annual written notice.

Approved by: Date:

PROCEDURE REFERENCE:

ADDRESSING MAJOR UNUSUAL INCIDENTS AND UNUSUAL INCIDENTS TO ENSURE HEALTH, WELFARE, AND CONTINUOUS QUALITY IMPROVEMENT

APPENDIX A

Administrative Investigation Procedure for Major Unusual Incidents in Category A

(Accidental or Suspicious Death, Exploitation, Failure to Report, Misappropriation, Neglect, Peer-to-Peer Act, Physical Abuse, Prohibited Sexual Relations, Rights Code Violation, Sexual Abuse, and Verbal Abuse)

- Findings in administrative investigations of major unusual incidents in Category A shall be based upon a preponderance of evidence standard. "**Preponderance of evidence**" means that credible evidence indicates that it is more probable than not that the incident occurred.

- There are three (3) possible findings of a Category A administrative investigation:

  - "**Substantiated**" means there is a preponderance of evidence that the alleged incident occurred;

  - "**Unsubstantiated/Insufficient Evidence**" means there is insufficient evidence to substantiate the allegation. "**Insufficient evidence**" means there is not a preponderance of evidence to support the allegation, or there is conflicting evidence that is inconclusive;

  - "**Unsubstantiated/Unfounded**" means the allegation is unfounded. "**Unfounded**" means the evidence supports a finding that the alleged incident did not, or could not have, occurred.

Steps for Investigating Major Unusual Incidents in Category A

FOR ALL CATEGORY A INVESTIGATIONS:

1) Commence the administrative investigation immediately, or no later than twenty-four (24) hours after discovery of the incident. "**Commencing the administrative investigation**" means any of the following:

   - Interviewing the reporter of the incident; or
   - Gathering relevant documents, such as nursing notes, progress notes, or incident report(s); or
   - Notifying law enforcement or the public children's services agency and documenting the time, date, and name of the person notified. If law enforcement or the public children's services agency decides not to conduct an investigation, the investigative agent shall commence the administrative investigation: or
   - Initiating interviews with witnesses or victims.

2) Interview the victim no later than three (3) working days following notification of the major unusual incident and document the results:

    - Exceptions to this requirement are when the individual is unable to provide any information, or the investigative agent determines that the circumstances warrant interviewing the individual later in the administrative investigation process.

3) Visit the scene of the incident.

4) Secure physical evidence:

    - Take photographs of injuries, as applicable;
    - Secure and sketch and/or photograph the scene of the incident;
    - Provide a detailed description of any injury that may have resulted from the incident, including the shape, color, and size of the injury;
    - Take a photograph of any injury that may have resulted from the incident;
    - Record the name of the person who took the photograph and the date and time the photograph was taken;
    - Provide a written description of the physical evidence along with the date, time, and location of the gathering of evidence;
    - Photograph and/or describe materials or objects that played a part in the incident;
    - Provide a written description, sketch, or photograph of the area where the incident occurred; and
    - Note any environmental factors that may have caused or contributed to any injury.

5) Follow-up with law enforcement:

    - Include a copy of the police report, as applicable.

6) Review all relevant documents relating to the primary person involved that form the basis for the reported incident and the relevant documents relating to the individual who is the alleged victim.

7) Interview persons who have relevant information about the incident, and document the interviews.

    - Interviews may be documented and statements taken via videotape, audiotape, or other means as appropriate; and
    - Gather written statements from all relevant witnesses.

8) Interview medical professionals as to the possible cause/age of the injuries, and document the interviews:

    - Include a statement from a qualified medical professional as to whether or not the injury is consistent with the description of the incident, including the apparent age of the injury and probable force necessary to cause the injury. Qualified medical professionals include, but are not limited to, physicians, nurses, emergency medical technicians, and therapists; and
    - Include a description of treatment received or ordered.

9) Conduct follow-up interviews if needed.

10) Evaluate all witnesses and documentary evidence in a clear, complete, and non-ambiguous manner.

11) Evaluate the relevant credibility of the witnesses. Factors to be considered in judging the credibility of a witness include:

- Whether the witness's statements are logical, internally consistent, and consistent with other credible statements and known facts (e.g. does the witness appear to omit or not know about information that he/she should know about?);
- Whether the witness was in a position to hear or see what is claimed;
- Whether the witness has a history of being reliable and honest when reporting incidents or making statements regarding incidents;
- Whether the witness has a special interest or motive for making a false statement (i.e. is there a possible bias of the witness?);
- The relevant disciplinary history of the primary person involved, such as involvement in similar past allegations;
- The witness's demeanor during the interview (e.g. did the witness appear evasive or not forthcoming?); and
- Whether the witness did other things that might affect his/her credibility.

12) Complete a written report that:

- Includes a clear statement of the allegation;
- Includes a succinct and well-reasoned analysis of the evidence;
- Includes a clearly stated conclusion that identifies which allegations were substantiated and which allegations were not substantiated; and
- Addresses preventive measures that have been implemented.

INCIDENT SPECIFIC REQUIREMENTS

ACCIDENTAL OR SUSPICIOUS DEATH

- Provide a statement explaining why the death is considered accidental or suspicious;
- Document relevant medical interventions, treatment, or care received by the individual;
- Include a copy of the police and/or coroner's investigation report; and
- Complete the required questions following deaths as specified by DODD.

EXPLOITATION OR MISAPPROPRIATION

- Document that there was an unlawful or improper act of using an individual, or an individual's resources, for monetary or personal benefit or gain of the primary person involved;
- Document the depriving, defrauding, or otherwise obtaining the real or personal property of an individual by means prohibited by the Ohio Revised Code. Include any indication of the intent of the primary person involved;
- Describe any items taken from the individual or anything received by the primary person involved as a result of the exploitation or misappropriation;
- Gather copies of all financial records related to the incident, including cancelled checks;
- Document the time, date, and officer's name for law enforcement agency notification;
- Include any indication that the individual may have consented or not consented to the taking of his or her property or to the exploitation;
- Verify the property belonged to the individual;
- Provide a description of how the improper act occurred; and
- Obtain the outcome of a criminal case, if resolved.

FAILURE TO REPORT

- Provide a statement indicating the abuse, neglect, exploitation, or misappropriation the primary person involved did not report, including when and how it occurred;
- Provide a statement indicating that the primary person involved was aware of the abuse, neglect, exploitation, or misappropriation, including when and how the primary person involved became aware of the abuse, neglect, exploitation, or misappropriation;
- Provide a statement of how the failure to report the abuse, neglect, exploitation, or misappropriation by the primary person involved caused physical harm, or a substantial risk of harm, to the individual. Be specific regarding any wound injury, or increased risk of harm to which the individual was exposed as a result of the failure to report;
- Explain why the primary person involved knew, or should have known, that the failure to report would result in a substantial risk of harm to the individual;
- Provide a written description of any injury;
- Provide an explanation from the primary person involved of why he/she failed to report; and
- Provide a statement of any reasons or circumstances explaining the failure to report by the primary person involved.

NEGLECT

- Verify and document the duty of the primary person involved to provide care to the individual;
- Document the treatment, care, goods, services, or supervision required, but not provided, by the primary person involved. Include the time period of the alleged neglect;
- Verify and document the primary person involved had knowledge that the withheld treatment, care, goods, services, or supervision was needed by the individual. Such documentation might include:
    - The individual's plan of care;
    - Medical information available to the primary person involved;
    - Statements made by the primary person involved; or
    - Training received by the primary person involved;
- Verify that the action, or inaction, of the primary person involved resulted in, or reasonably could have resulted in, harm to the individual; and
- Specifically describe the harm or risk to the individual caused by the action, or inaction, of the primary person involved.

PEER-TO-PEER ACTS

- Verify and document that the proper supervision and supports were provided to all individuals;
- Determine that the major unusual incident is properly coded;
- Describe the act in detail;
- Document all of the involved individuals' histories and the history, if any between the individuals;
- Describe what preceded the incident, and what action was taken at the time and immediately after the incident; and
- Document attempts to notify the individual's guardian prior to interviewing the individual.

PHYSICAL ABUSE

- Provide written statements that include a description of the amount of physical force used, which may include, but is not limited to:
    - Speed of the force;
    - Range of motion;
    - Open or closed hand (fist;
    - The sound made by impact;
    - Texture of surface if the individual was dragged or pulled; and
    - The distance the individual was dragged pulled, or shoved;
- Provide a description of the individual's reaction to the physical force used (e.g., the individual fell backward or the individual's head or other body part jerked backward), and any indication of pain or discomfort experienced by the individual which may include words, vocalizations, or body movements;
- Include comments made during the incident by the primary person involved; and
- Document how the harm to the individual is linked to the force used by the primary person involved.

PROHIBITED SEXUAL RELATIONS

- Describe and document the type of sexual conduct or contact;
- Document whether or not the incident was consensual (Note: Consent does ***not*** excuse sexual contact by a caregiver with an individual, when the caregiver is paid to care for the individual.)
- Verify and document that the primary person involved was providing paid care to the individual;
- Verify and document that the primary person involved was not married to the individual; and
- Provide a statement of any known, long-term, personal relationship the primary person involved has with the individual, or other circumstances relevant to the sexual contact or conduct.

RIGHTS CODE VIOLATION

- Indicate the specific right or rights of the individual violated by the primary person involved, and describe how each right was violated, including any information or circumstances relevant to the incident; and
- Describe the harm, or risk of harm, caused to the individual as a result of the rights code violation by the primary person involved.

SEXUAL ABUSE

- Document that the sexual activity was unwanted, or the individual was unwilling;
- Document that the primary person involved engaged in importuning, voyeurism, public indecency, pandering, or prostitution with regard to an individual;
- Document the individual's capacity to consent;
- Document any touching of an erogenous zone for the apparent sexual arousal or gratification of either person;
- Describe the sexual conduct/contact, including any penetration of the individual;
- Include the results of any physical assessment conducted by a medical professional;
- Include the results of any human sexuality assessment;
- Provide a copy of the police report;
- Include all medical information related to the incident; and
- Document the date, time, and officer's name for law enforcement agency notification.

VERBAL ABUSE

- Provide a statement of the exact words or gestures used to threaten, coerce, intimidate, harass, or humiliate the individual, and the context in which these were used;
- Provide a description of the reaction of the individual to the words of gestures, including any words or vocalizations;
- Describe the volume used, including such descriptions as loud, soft, and tone of voice, and where the primary person involved was located in relation to the individual; and
- Describe the past history of verbal interactions between the primary person involved and the individual.

PROCEDURE REFERENCE:

ADDRESSING MAJOR UNUSUAL INCIDENTS AND UNUSUAL INCIDENTS TO ENSURE HEALTH, WELFARE, AND CONTINUOUS QUALITY IMPROVEMENT

APPENDIX B

Administrative Investigation Procedure for Major Unusual Incidents in Category B

(Attempted Suicide, Death Other than Accidental or Suspicious Death, Medical Emergency, Missing Individual, and Significant Injury)

Steps for Investigating Major Unusual Incidents in Category B

1) Determine that the major unusual incident is properly coded;
2) Review relevant documents which may include recent medical history, individual service plan, progress notes, nursing notes, hospital records, police report, and/or behavior support documentation;
3) Interview witnesses as necessary to determine the cause, or, to resolve conflicting information;
4) Interview others with relevant information as necessary;
5) Maintain summary of each interview conducted;
6) Identify the causes and contributing factors to the incident;
7) Review past related incidents, as appropriate, including, but not limited to, prior immediate health and welfare measures taken and other preventive measures; and
8) Verify that preventive measures have been implemented.

PROCEDURE REFERENCE:

ADDRESSING MAJOR UNUSUAL INCIDENTS AND UNUSUAL INCIDENTS TO ENSURE HEALTH, WELFARE, AND CONTINUOUS QUALITY IMPROVEMENT

APPENDIX C

Administrative Investigation Procedure for Major Unusual Incidents in Category C

(Law Enforcement, Unapproved Behavior Support, and Unscheduled Hospitalization)

1) The following information shall be collected for major unusual incidents in Category C;

2) The investigative agent shall review the information to ensure that the information is complete, and the major unusual incident is properly coded; and

3) Information collected does not take the place of an incident report.

INCIDENT SPECIFIC REQUIREMENTS

LAW ENFORCEMENT

- Provide the name, title, and phone number of the person reporting to the county board;
- Provide prior history of law enforcement involvement;
- Describe the individual's activities prior to the incident (e.g., followed normal routine);
- Record the individual's supervision level and whether the supervision level was met;
- Describe immediate actions taken to ensure health and welfare (e.g., alerting jail of medical concerns and dietary restrictions, or ensuring medications are available to the individual);
- Describe the incident in detail;
- Describe injuries, if any, to the individual, or to the individual's victim;
- Include outcome of court hearing;
- Identify cause and contributing factors; and
- Verify that preventive measures have been implemented.

UNAPPROVED BEHAVIOR SUPPORT

- Provide name, title, and phone number of person reporting to the county board;
- Indicate whether or not the individual has a behavior support plan;
- Describe what happened prior to the incident and develop a timeline;
- Describe the intervention used;
- Indicate whether the individual was injured and if excessive force was used;
- Explain the health and welfare risk;
- Document how long the unapproved behavior support lasted;
- Describe what, if any, other measures were taken first;
- Identify cause and contributing factors; and
- Verify that preventive measures have been implemented.

UNSCHEDULED HOSPITALIZATION

- Provide name, title, and phone number of person reporting to the county board;
- Provide a list of documents reviewed;
- Address the individual's medial history (e.g., recent similar illnesses or chronic/acute conditions);
- Describe the individual's health during prior seventy-two (72) hours;
- Document date and reason for most recent prior hospitalization;
- Indicate if the symptoms were addressed in a timely manner, and if not, explain why;
- Describe incident;
- Include diagnosis, discharge summary, and follow-up appointment information;
- If individual had flu or pneumonia, indicate whether or not he/she received a flu shot or pneumonia vaccine;
- Identify cause and contributing factors; and
- Verify that preventive measures have been implemented.

PROCEDURE REFERENCE:

ADDRESSING MAJOR UNUSUAL INCIDENTS AND UNUSUAL INCIDENTS TO ENSURE HEALTH, WELFARE, AND CONTINUOUS QUALITY IMPROVEMENT

APPENDIX D

County Board Contact Information

As referenced in Sections IV (F) and IV (K) of this procedure, the county board shall have a system that is available twenty-four (24) hours a day, seven (7) days per week, to receive and respond to all reports required by OAC 5123:2-17-02.

During normal business hours, notification shall be made by calling:

After hours, and on weekends or holidays, notification should be made by calling:

Written incident reports shall be submitted no later than 3:00 p.m. the next working day following the discovery of the incident. Said reports should be submitted in the following manner and to the following entities:

Effective Date: 4-1-2014

Approved By: Mathual J. Campbell, Superintendent