Unity House of Cayuga County Inc.
Policy and Procedure

Category: 1600 - General Policies

Policy: 09 - Incident Management Policy and Procedure

Effective Date: 11.2014
Revision Dates: 12.2014, 10.2016, 4.2017, 11.2017, 3.2019, 7.2020, 9.2021, 5.2022. 6.2023
Reviewed Dates: 12.2014, 10.2016, 4.2017, 11.2017, 3.2019, 7.2020, 9.2021, 5.2022, 1.2023, 6.2023

Office Responsible for Development and Review of this Policy: Quality Improvement

I. Purpose:

Unity House of Cayuga County Inc. provides OPWDD, OMH, and OASAS services that empowers and enrich the lives of people diagnosed with an intellectual or developmental disability, mental health and substance use. This is accomplished by offering supports and services in an inclusive, person-centered environment. In addition, Unity House staff seeks to ensure the safety and well-being of all its residents and program participants.

II. Scope:

Applies to all employees of Unity House.

III. Policy:

It is the policy of Unity House of Cayuga Co. Inc. to identify, report, investigate and review all untoward events, situations, significant incidents and allegations of abuse to persons served in accordance with the Justice Center Regulations, OPWDD Part 624 and 625 regulations, OMH 524 regulations and OASAS 836 regulations. All information and investigative materials related to incidents will be handled in a confidential manner. This policy will be made known to all persons served, parents, guardians, correspondents or advocates; and to employees, Board of Directors, interns, volunteers, consultants and contractors upon admission/employment and annually. This will be done through training, and/or by providing a copy of the policy.

The purposes for reporting, investigating, reviewing, correcting and/or monitoring certain events or situations are to enhance the quality of care provided to persons who receive Unity House services and supports, to protect them (to the extent possible) from harm, and to ensure that such persons are free from mental and physical abuse.

IV. Procedure

The Protection of People with Special Needs Act (Justice Center):
The Protection of People with Special Needs Act (The Act) established the Justice Center on June 30, 2013.

The Act requires that their **Code of Conduct** must be read and signed by anyone who will have regular and substantial contact with any person who is receiving services or supports from facilities or providers covered by the Act. This includes OPWDD, OMH, and OASAS services provided at Unity House. The Code of Conduct represents a framework that will help custodians determine how to help people with special needs live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm. The Code of Conduct is reviewed and signed by all staff at their time of hire and annually thereafter.

Notice to Mandated Reporters identifies legal duties under the New York State Protection of People with Special Needs Act to report Abuse, Neglect and Significant Incidents involving vulnerable persons to the Vulnerable Persons' Central Register (VPCR), a 24/7 hotline operated by the Justice Center for the Protection of People with Special Needs, effective June 30, 2013. Custodians (employees, volunteers, interns, consultants, contractors and family care providers and operators of covered facilities and programs) having regular and substantial contact with people being served and Human Service Professionals must report to the VPCR abuse, neglect and significant incidents.

Whenever a Mandated Reporter has reasonable cause to suspect a Reportable Incident involving a vulnerable person, he or she is required to make a report to the VPCR immediately upon discovery. Immediately means "right away"; must be made to the VPCR within 24 hours. VPCR hotline number: 1-855-373-2122. Further questioning of individuals and witnesses should cease to allow the investigation to progress, maintain confidentiality and minimize discussion about the incident amongst persons involved and other program staff.

Safeguards/Protections: The individual's safety must always be the primary concern. The program 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 the individual from harm or abuse.

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

Agencies are required to report to law enforcement any time a custodian may have committed a crime against an individual receiving services.

Programs covered under The Act: Facilities and programs that are operated, certified, or licensed by OPWDD, OMH, OASAS, the Office of Children and Family Services (OCFS), Adult Homes licensed by DOH, and certain programs approved by the New York State Education Department (NYSED).

What Constitutes Abuse or Neglect?
The Act defines Abuse and Neglect in broad terms including both actual harm and the risk of harm.

Incident Management Training: Incident Management training, including all incident classifications, will be provided to all staff at their time of hire and annually thereafter.

Abuse and Neglect are defined by the Justice Center and apply to all programs covered under The Act.

Physical Abuse	Conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury by means of slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, corporal punishment, etc.
Sexual Abuse	Any sexual contact between an individual receiving services and a custodian of the program; whether or not the contact would constitute a crime.
Psychological Abuse	Any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services. Example include: taunts, derogatory comments or ridicule, intimidation, threats or the display of a weapon.
Deliberate Inappropriate Use of Restraints	Use of restraint deliberately inconsistent with an individual's plan. Restraint will include manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person to freely move his or her arms, legs or body.
Use of Aversive Conditioning	Application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person. I.e.. Noxious odors, noxious tastes, blindfolds, withholding of meals, food in an unpalatable form.
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; suppressing the reporting of the incident to the VPCR; intentionally making a false statement or intentionally withholding information; intentional failure of a supervisor to act on a report per the regulations; for a custodian, failing to report a reportable incident upon discovery.

Unlawful Use or Administration of a Controlled Substance	Administration by a custodian to a service recipient of a controlled substance without a prescription, or other medication not approved for any use by the FFDA. Also includes a custodian unlawfully using or distributing a controlled substance at the workplace or while on duty.
Neglect	The 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 impairment of the physical, mental, or emotional condition of a service recipient. This shall include: Failure to provide proper supervision that results in conduct between persons receiving services that would constitute abuse if committed by a custodian; Failure to provide adequate food, clothing, shelter, or medical, dental, optometric or surgical care; Failure to provide educational entitlements.

The Act defines a Significant Incident as an incident that is not abuse or neglect, but has the potential to result in harm to the health, safety, or welfare of a person receiving services. Significant Incidents are defined differently by each agency governed by the Act and they will be listed later in the policy.

Programs certified by OPWDD, OMH, and OASAS report reportable incidents to the Justice Center along with the all other appropriate parties. Non-certified programs report incidents to their governing agency and but do not report to the JC. All other aspects of notification, investigation and follow up remain the same.

All Reportable Incidents, including allegations of abuse and neglect, will be investigated. If an employee leaves employment prior to the conclusion of a pending investigation, the investigation shall continue until it is completed and for abuse/neglect allegations, a finding is made of substantiated or unsubstantiated.

One-on-One Interaction:
Most abuse occurs when an adult is alone with a service recipient. Our organization aims to minimize the risk involved in these situations – both for the individual and the staff. In one-on-one situations, staff should observe the following additional guidelines to manage the risk of abuse or false allegations of abuse:

- When meeting one-on-one with a service recipient, do so in a public place where you are in full view of others.
- Avoid physical affection that can be misinterpreted. Limit affection to pats on the shoulder, high-fives and handshakes.
- If meeting in a room (i.e. bathroom, bedroom) or office, leave the door open or move to an area that can be easily observed by others passing by.
- Inform other staff that you are alone with a service recipient and ask them to randomly drop in.
- Document and immediately report any unusual incidents, including disclosures of abuse, behavior problems and how they were handled, injuries, or any interactions that might be misinterpreted.

Off-Site Contact:
Some cases of abuse occur off-site. This may put staff at increased risk.
Activities to minimize risk:

- Taking groups of individuals on an outing
- Attending functions at an individual's home with the parents/guardians present
- Never taking an individual to the staff's home
- Doing activities in public places where you are in full view of others

How to report:
Call the VPCR at 1-855-373-2122, submit the report via web form, or use the JC App. The VPCR phone number is provided at all program sites.

What happens when a report is made to the VPCR?
Trained VPCR staff will take a full report over the phone or via a web form, or an app, and, based upon the information provided, will categorize the reportable incident (abuse, neglect, significant incident) and notify the appropriate SOA (State Operated Agency). The Justice Center will be responsible for ensuring that the reportable incident is investigated or reviewed by the appropriate entity.

What protections and liabilities do mandated reporters have?
Immunity from liability – the law grants immunity to Mandated Reporters and other reporters from any legal claims which may arise from a good faith act of providing information to the VPCR.

Protection from Retaliatory Personnel Action – The law prohibits an employer or agency from taking any retaliatory personnel action against a person as a result of a good faith act of providing information to the VPCR.

Confidentiality – The law provides protections against the disclosure of the reporter's identity subject to limited exceptions.

Failure to Report
Failure by a Mandated Reporter to report suspected Abuse or Neglect to the VPCR is a serious matter and possible consequences include administrative discipline, termination, civil liability and criminal prosecution.

How to Report Patient Deaths to the Justice Center:

- Call the JC Death Reporting Line at 1-855-373-2124 to make the initial report immediately upon discovery; and in no case more than 24 hours after discovery. All deaths must also be reported to the SOA.
- Death of a client of a State operated or licensed provider who was enrolled in or receiving services from the facility or program at the time of death or any patient death occurring within 30 days of discharged from the program must be reported to the JC and SOA.
- After the report is made to the JC, the information will be transferred to the State Operated Agency. The program must complete the *Report of Death to the Justice Center* within 5 days of the initial report to the JC. For OPWDD and OMH, this is done

through IRMA and NIMRS, respectfully. For OASAS, the hard copy form must be completed and faxed to the JC.
- If the death is the result of abuse/neglect, the incident must be called into the JC VPCR Hotline and called into the Death Reporting Line.
- Results of an autopsy, if available, must be submitted to the JC and OPWDD within 60 working days of discovery of the death.
- A death that did not occur under the auspices of an agency (died in his/her private home) must be reported in accordance with Part 625.

Incident Review Committee (IRC)

Composition: Per the PPSNA, IRC membership must *exclude* a provider's director (CEO), but must include, but not limited to:

- Member of the governing body (BOD)
- At least two professional staff. At least one profession staff must be a licensed health care practitioner (physician, physician's assistant, nurse practitioner, or RN)
- Other staff, including administrative staff
- Direct Support Professional
- Service Recipient
- Family/consumer/advocacy organization representative
- Psychologist is recommended
- OMH requires a physician on a regular membership or ad hoc basis. The physician shall participate in review of all medically related incidents.

Confidentiality: Members maintain confidentiality of protected health information (PHI) and receive HIPAA training.

Unity House's IRC meets one time each month to review all reportable incidents and 625 events/situations. They review the investigation report and/or follow up information regarding the incident/situation. The IRC ensures that all recommendations of the investigation are addressed and/or all corrective action is completed by ascertaining that necessary and appropriate corrective, preventive, remedial and/or disciplinary action has been taken to protect person receiving services from further harm, to safeguard against the recurrence of similar reportable incidents and notable occurrences and to make written recommendations to their chief executive officer to correct, improve, or eliminate inconsistencies. IRC must ascertain if further investigation or if additional corrective, preventive, remedial, and/or disciplinary action is necessary, and if so, make appropriate written recommendations to the chief executive officer relative to the reportable incident or notable occurrence. Should the IRC recommend additional corrective measures or changes, this information will be communicated by the IRC Chairman to the appropriate Program Director. Their response to the recommendations is provided to the IRC at their next meeting. IRC will identify trends in reportable incidents and notable occurrence (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 incident and notable occurrences. IRC will 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.

IRC Chair will ensure that minutes are kept for all meetings. IRC Chair will provide minutes to the CEO within 2 weeks. The portion of the minutes that discuss matters concerning the specific event or situation shall be entered into IRMA/NIMRS within three weeks of the meeting.

When an investigation of an incident or occurrence is conducted by the Central Office of OPWDD/OMH or the Justice Center, the IRC role in reviewing and monitoring the particular incident or occurrence is limited to matters involving compliance with the reporting and notification requirement of this part, protective and remedial actions taken, operational concerns and the quality of services provided.

The IRC Chair will submit an Annual Report to the Board of Directors concerning the Committee's general function, and identified trends in incidents and allegations.

Jonathan's Law

Jonathan's Law established procedures that facilities must follow to notify and inform parents and legal guardians of children and adults receiving certain services (including OPWDD, OMH, and OASAS) of incidents involving their loved ones. It also allows a qualified person to access certain documents pertaining to such incidents.

Under the law, qualified persons include:

- Parents or other legal guardians of minor patients;
- Parents, legal guardians, spouses, or adult children of adult patients who are legally authorized to make health care decision on behalf of the adult patient; or
- Adult patients who have not been determined by a court to be legally incompetent.

A facility will inform the qualified person(s) by telephone of accidents or injuries that affect the health or safety of an individual receiving services within 24 hours of the initial report of the incident. If requested by a qualified person, the facility must promptly provide a copy of the written incident report. The facility must also offer to meet with the qualified person to further discuss the incident. The director of the facility must provide the qualified person(s) with a written report on the immediate actions taken to address the incident (e.g. steps taken to protect the involved individual) within 10 days of the initial report of the incident.

If requested by the qualified person in writing, Jonathan's Law requires facilities to provide records and documents pertaining to allegations and investigations into abuse, neglect, and significant incidents to the qualified person(s). These documents must be provided within 21 days after the investigation is concluded. The names or information that identifies other persons receiving services and employees will be redacted unless these individuals authorize disclosure. Federal laws or regulations may pose additional restrictions on the release of records or information contained in those records.

Records subject to release will be monitored and addressed by the DQA or designee.

Work Flow for Investigations

Report is made to the NYS Justice Center via phone or Web form or App

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VPCR Staff will classify the Report as:
Abuse/Neglect
Significant Incident
Death
Non-NY JC Incident
Not an Incident

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XML detailing the incident is sent to OPWDD/OMH/OASAS Central Office from the NYS Justice Center

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XML detailing the incident is assigned to the investigating entity (JC, SOA, Agency)
(If the JC is assigned the investigation, they will complete the investigation and submit to the JC General Counsel for review)
If the agency is assigned the investigation, see below:

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Process for Allegations of Abuse/Neglect:

1. Agency completes the investigation with 30 days (OPWDD/OMH), 21 days (OASAS), attaches all investigative materials need to be submitted to OPWDD/OMH/OASAS within 45 days.
2. Investigation packet is reviewed by SOA and submitted to the NYS JC by the SOA within 50 days of the report date.
3. JC reviews the incident and sends to their General Counsel's office.
4. The General Counsel's office reviews the incident and sends the agency, the individual, and the parent/legal guardian (if applicable) the Letter of Determination regarding the outcome of the investigation.
5. The Corrective Action Plan is submitted to the SOA and JC within 60 days from the date of the Letter of Determination

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Process for Significant incidents:

1. Incident must be imported from the JC Portal into IRMA/NIMRS and edited appropriately.
2. The incident must be investigated.
3. The incident must be reviewed by IRC and closed within 45 days.
4. The investigation, corrective action, and IRC minutes are entered into the electronic data base (IRMA/NIMRS). For OASAS, the final report is sent to OASAS.

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Process for Deaths:

1. Incident must be imported from the JC portal into IRMA/NIMRS
2. Report of Death must be submitted to the JC (through IRMA/NIMRS or hard copy for OASAS) within 5 days.
3. For OPWDD, all deaths must be investigated. Final report sent to OPWDD for submission to the Mortality Review Committee.

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For Non-NY JC Incidents:
If the incident falls into another category, reportable to SOA, edit and address appropriately.
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Not an Incident:
No further action required.

The Definitions of each of the Significant Incident and other categories below are listed in Appendix A, B, C at the end of this document for OPWDD, OMH, and OASAS.

OPWDD – Reportable to JC and OPWDD

Significant Incidents:
Conduct Between Persons Receiving Services
Seclusion
Unauthorized Use of Time Out
Medication Error with Adverse Effect
Inappropriate Use of Restraints
Mistreatment
Missing Person at Risk for Injury
Unauthorized Absence
Choking with Known Risk
Choking with No Known Risk
Self-Abusive Behavior with Injury
Injury with Hospital Admission
Theft/Financial Exploitation
Other Significant Incident

OPWDD – Reportable to OPWDD Only

Minor Notable Occurrences
Injury (Document in IRMA only)
Theft or Financial Exploitation (Notification to OPWDD and entry into IRMA)

Serious Notable Occurrences
Death
Sensitive Situation

Agency Minor Incidents (Agency Internal Occurrences [Minors] – process for managing minor incidents is found in a separate policy.)
Minor Injury (bruises, burns, sun burns, abrasions, insect bites with allergic reaction, etc.)
Falls

OPWDD 625 Regulations – Events/Situations that are not under the auspices of the agency: (see 625 regulations below)
Physical Abuse
Sexual Abuse
Passive Neglect
Active Neglect
Self-Neglect
Financial Exploitation
Emotional Abuse
Death
Other

OMH – Reportable to JC and OMH

Applies to certified programs under OMH.
Significant Incidents:
Assault
Crime
Falls by Patients
Fights
Financial Exploitation
Fire Setting
Injury of Unknown Origin
Medication Error
Missing Patient
Mistreatment (Unauthorized Restraint or Seclusion. Inappropriate use of Time Out, Intentional Improper Administration of medication)
Self-Abuse
Severe Adverse Drug Reaction
Sexual Assault
Sexual Contact Between Children
Suicide Attempt
Verbal Aggression by Patients
Wrongful Conduct
Other Incident

OMH – Reportable to OMH Only

Serious Crimes in the Community
Missing Subject of AOT Order
Suicide Attempt Off Site

OASAS – Reportable to JC and OASAS

Significant Incidents:
Conduct Between Individuals Receiving Services
Unauthorized Seclusion
Unauthorized Time Out
Medication Error with Adverse Effect
Inappropriate Use of Restraints
Crime
Body Cavity Search
Violation of Confidentiality
Death
Missing Client
Suicide Attempt
Physical Plan Issues Leading to Incidents
Lack of Food/Nutrition
Inadequate Supervision resulting in an Incident
Inappropriate Relationships between staff and client
Overdose
Any ER visit
Medication Errors
Any First Responder called to a certified site
Fire Setting

Agency Process for completion of documentation and notifications for each incident:

Upon 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.

Report of an incident is made to the JC, SOA or Agency of a Reportable, Significant Incident or SOA reportable incident, Serious Notable Occurrence or Minor Notable Occurrence

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Immediate protections must be put in place for the individual.

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All appropriate notifications are made immediately upon occurrence or discovery, no later than 24 hours, as appropriate:

Justice Center
SOA
Executive Director
Family/Legal Guardian/Advocate
Care Manager
Clinician
Program Director
MHLS, if applicable (within 72 hours)
Police (Law Enforcement must be contacted immediately for allegations of physical and sexual abuse or crime against the individual)
EMS
Adult Protective Services
NYS Child Abuse
CAB
All other appropriate entities

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Depending on the category, the incident is edited by the program in IRMA/NIMRS or entered into the data base within 24 hours or by the close of the next working day, whichever is later.

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The Program Director or QI will review the information within 24 hours and will update/report missing or discrepant information.

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NIMRS/IRMA should be updated with new information has appropriate.
NIMRS entries must be emailed to OMH.

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An investigation shall commence immediately by the CEO, COO, CCO, IMM, and QIS and must be completed within 30 days from the date of report. For allegations of abuse/neglect, the CCO or designee will send the Letter to the Target of the Investigation immediately following notification of the incident.

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The Investigation Report with the conclusions and recommendations will be submitted to the Executive Director, COO, Program Director and HR (as needed) for review and to address the recommendations presented in the investigation.

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CCO or designee will present the investigation report, notifications, and initial IRMA/NIMRS/incident report to the IRC for their review within one month.

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CCO or designee will ensure the entire investigatory record is submitted to the JC and SOA within 50 days.

Weingarten Rights: An employee is entitled to union representation when all of the following conditions are met: (1) the employee must be questioned in connection with an investigation; (2) the employee must reasonably believe he or she may be disciplined as a result of the answers; and (3) the employee must request representation.

OPWDD 625 Regulation (Categories identified above):

If an agency becomes aware of an event or situation involving an individual receiving services, the agency should take action to protect the involved individual. This may include:

- Notify an appropriate party that may be in a position to address the situation (i.e. Adult Protective Services, law enforcement officials, family members, school, hospital, etc.);
- offer to make referrals to appropriate service providers, clinicians, State agencies or other parties;
- interviewing the involved individual and/or witness;
- assessing and monitoring the individual, reviewing records and other related documentation; and/or
- educating the individual about his or her choices and options regarding the matter.

The agency must submit an initial report about the event/situation in IRMA within 24 hours of the occurrence or discovery or by the close of the next working day, whichever is later. Actions taken by the agency to protect the individual must be documented in IRMA.

The agency must report updates on a monthly basis (or more frequently) until the situation is resolved.

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 the agency shall be reported to OPWDD immediately upon discovery by telephone. The agency shall submit an initial report about the death in IRMA within 24 hours of discovery of the death, or by close of the next working day, whichever is later. The agency shall submit subsequent information about the death in IRMA within 5 working days following the discovery of the death.

OPWDD: RIA (Restrictive Intervention Application)

Effective July 30, 2012, the use of a restrictive physical intervention technique is required to be reported electronically to OPWDD within 5 days of occurrence in IRMA.

It is used by OPWDD for the tracking and trending of the requisite restrictive personal/physical intervention data on a statewide basis. RIA will enhance the agency's

ability to track, trend, and analyze the relationship between restrictive personal/physical interventions and untoward events with the ultimate goal being to reduce and/or ameliorate resulting injuries and allegations of abuse.

All current users in IRMA will automatically have access to the RIA in IRMA.

Records Retention:

Agencies must retain records pertaining to incidents and allegations of abuse/neglect for a minimum time period of ten years from the date that the incident or allegation of abuse is closed.

For additional information on incident management regulations, refer to OPWDD's 624 and 625 regulations, OMH's 524 regulations and OASAS' 836 regulations.

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Justice Center "Reportable Incident" classifications –

Occur under the auspices of the agency. Report to the Justice Center for certified programs only. Notify OPWDD, UH CEO, COO, Dept Dir, Dept Mgr., QA, Care Coordinator, Emergency Contact, etc. Jonathans Law notification is required. Notification to MHLS is required for all allegations of abuse/neglect. If substantiated; do not bill for time incident occurred.

Abuse/Neglect - *Conduct by an employee*

Physical Abuse	Conduct by an employee, intentionally or recklessly causing physical injury by means of slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, corporal punishment, etc. Administrative leave is required for the target. The police must be called.
Sexual Abuse	Sexual contact between a service recipient and an employee; whether or not the contact would constitute a crime. Administrative leave is required for the target. The police must be called.
Psychological Abuse	Verbal or nonverbal conduct by an employee that may cause significant emotional distress to a service recipient; taunts, derogatory comments, ridicule, intimidation, threats or the display of a weapon.
Deliberate Inappropriate Use of Restraints	Use of restraint deliberately inconsistent with an individual's plan. Restraint includes manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a service recipient to freely move their arms, legs or body.
Aversive Conditioning	Application of a physical stimulus by an employee that is intended to induce pain or discomfort in order to modify or change the behavior of a service recipient; noxious odors, noxious tastes, blindfolds, withholding of meals, food in unpalatable form.
Obstruction of Reports of Incidents	Conduct by an employee that impedes the discovery, reporting or investigation of an incident by falsifying records related to the safety, treatment or supervision of a service recipient; suppressing reporting of the incident to the Justice Center; intentionally making a false statement, intentionally withholding information; intentional failure of a supervisor to act on a report per regulations; or an employee failing to report a reportable incident upon discovery.
Unlawful Use or Administration of a Controlled Substance	Administration by an employee to a service recipient of a controlled substance without a prescription, or other medication not approved for any use by the FDA; including an employee unlawfully using or distributing a controlled substance at the workplace or while on duty.
Neglect	Action, inaction, or lack of attention that breaches a custodian's duty and results in or is likely to result in physical injury or serious impairment of the physical, mental, or emotional condition of a service recipient. This includes: failure to provide proper supervision that results in conduct between service recipients, failure to provide adequate food, clothing, shelter, medical, dental, optometric or surgical care; failure to provide educational entitlements. The police must be called for egregious Neglect.

Justice Center Reportable Significant Incident classifications: **The severity of the situation, may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a service recipient. Report to the Justice Center. Notify OPWDD, UH CEO, COO, Dept Dir, Dept Mgr., QA, Care coordinator, Emergency Contact, etc.**	
Conduct Between Service Recipients	Physical conduct between service recipients, intentionally or recklessly causing physical injury requiring more than First Aid. Sexual conduct between service recipients; (both receive services); one or both are not able to determine consent. Sexual contact between service recipients; one or both are not able to determine consent and coercion/force was used.
Seclusion	Conduct on the part of an employee that is inconsistent with a service recipients service plan; placement of an individual in a room or area from which he or she cannot, or perceives that they cannot leave at will.
Unauthorized Use of Time-Out	A service recipient removed from regular programming to isolate in a room or area for the convenience of an employee or as a substitute for programming; sending them to their room.
Medication Error with Adverse Effect	Administration of a prescribed or over-the-counter medication, which is inconsistent with the administration directions resulting in adverse effect on a service recipient. Adverse effect: the unanticipated, undesirable or unfavorable side effect.
Inappropriate Use of Restraints	Use of a restraint when the technique used, the amount of force used, or the situation in which the restraint is used is inconsistent with a service recipients service plan and/or generally accepted treatment practices. Restraint includes any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person to freely move their arms, legs or body.
Mistreatment	Conduct of an employee that is inconsistent with the service recipients service plan, generally accepted treatment practices, applicable laws, regulations or policies, that impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of a service recipient.
Missing Person at risk for injury	The unexpected absence of a service recipient that, based on the person's history and current condition, exposes them to risk of injury.
Unauthorized Absence	Unexpected or unauthorized absence of a service recipient after formal search procedures have been initiated by the agency. Take into consideration their habits, deficits, capabilities, health and safety concerns to determine when formal search procedures must be initiated; immediately upon discovery of an absence involving a service recipient whose absence constitutes a recognized potential danger to their well-being or others.
Choking with Known Risk	Partial or complete blockage of the upper airway by an inhaled or swallowed foreign object or food that leads to a partial or complete inability to breathe requiring physical intervention to clear the blockage. Known risk for choking and a written directive addressing that risk.
Choking with no Known Risk	Partial or complete blockage of the upper airway by an inhaled or swallowed foreign object or food that leads to a partial or complete inability to breathe requiring physical intervention to clear the blockage. No known risk for choking: no concern to require a plan in place to address choking risks.

Self-Abusive Behavior w/Injury	Self-inflicted injury by a service recipient that requires medical care **beyond first aid**.
Injury with hospital admission	**Injury** requiring hospitalization. (Illness are not included.)
Theft/ Financial Exploitation	Suspected theft of a service recipient's personal property 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). The police must be called.
Other Significant Incident	Occurs under the auspices of the agency, but that does not involve conduct on the part of an employee and does not meet the definition of any other incident described in 624. However, because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in harm to the health, safety, or welfare of a person receiving services.

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revised 3/2023

Serious Notable Occurrences - Sensitive Situations: do not report to the Justice Center; reportable to OPWDD only. Notify OPWDD, UH CEO, COO, Dept Dir, Dept Mgr., QA, Care Coordinator, Emergency Contact, etc.	
Death	Death of any person receiving services, regardless of the cause of death. All deaths of individuals who live in residential facilities operated or certified by OPWDD and other deaths that occur under the auspices of the agency. Only 1 person from the agency calls the death reporting line (person with most information); 1-855-373-2124 - Death reporting line. **ONLY** if the death appears to be the result of abuse or neglect, the JC VPCR needs to also be called.
Sensitive Situation	Situation of delicate nature to the agency. Includes possible criminal acts committed by an individual receiving services.

Minor Notable Occurrences - Do not report to the Justice Center; reportable to OPWDD only through an IRMA entry. Notify OPWDD, UH CEO, COO, Dept Dir, Dept Mgr., QA, Care Coordinator, Emergency Contact, etc.	
Injury	Injury that requires more than first aid. Illness is not reportable.
Theft or Financial Exploitation	Suspected theft of a service recipient's supervised personal property or financial exploitation involving values of more than $15 and less than or equal to $100. If unsupervised spending is missing, not reportable to OPWDD or JC; unless the individual has alleged a theft - then reportable to OPWDD. The police must be called.

Part 625 Events/Situations: do not occur under the auspices of an agency. Do not report to the Justice Center. Phone notification to OPWDD for Physical Abuse only is required. Must be entered in IRMA within 48 hours. For Supportive Apartments, if staff *were not* providing oversight at the time of the event/situation, it is Part625. If staff *were* providing oversight, it is Part 624. Notify OPWDD, UH CEO, COO, Dept Dir, Dept Mgr., QA, Care Coordinator, Emergency Contact, etc.

Physical Abuse	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.
Sexual Abuse	Non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact or forcing sex with a third party.
Passive Neglect	Non-willful failure of a caregiver to fulfill functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, denial of food, health related services **because of inadequate caregiver knowledge, infirmity or disputing the value of prescribed services.**
Active Neglect	Willful failure by a caregiver to fulfill the 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.
Self-Neglect	Service Recipient's inability, due to physical and/or mental impairments, to perform tasks essential to care for oneself, including but not limited to, providing essential food, clothing, shelter, medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety or managing financial affairs.
Financial Exploitation	Use of a service recipient'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.
Emotional Abuse	Willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other abusive conduct, including but not limited to, frightening or isolating a service recipient.
Death	Expected or unexpected end of life, regardless of cause.
Other	Possible Criminal Acts, missing persons, sensitive situations of significant concern.

Agency Reportable Minor Incident: A noteworthy event or situation that does not endanger the general wellbeing of the service recipient and does not meet the definition of a reportable incident; cause known or of unknown origin. Agency reportable only in Foothold.

Fall	Require only first aid. Nursing must be notified of all falls. For a fall with head injury or trauma, follow the head injury protocol and implement neurological checks. For unwitnessed falls neurological checks need to be implemented.
Minor Injury	Bruise, scratch, abrasion, burn or sunburn; approximate width of a quarter or larger. Human bite causing skin break. Insect bite showing signs of an allergic reaction.

OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTABILITY

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

Incident Type – Sub Type		Definition	Required Reporting
Abuse and Neglect **Report to JC & OMH**	**Allegation of Abuse and Neglect:** Abuse and neglect involve an act (or failure to act) by an employee.		
	Physical Abuse	**Intentional or reckless contact with a client which causes or has the likelihood of causing physical pain or harm.**	**Report to JC & OMH** **1. Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WI/ **2. Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Queue in NIMRS. The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and submit the investigation via WSIR within 45 days.
	Psychological Abuse	**Verbal or nonverbal conduct that intentionally or recklessly causes a patient emotional distress.**	
	Sexual Abuse	**Any sexual contact involving a custodian and a patient, or any legal sexual contact involving a patient that is encouraged or allowed by a custodian.**	
	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 patient.**	
	Deliberate Inappropriate Use of Restraint	**Use of restraint for any reason other than as an emergency safety intervention.**	
	Obstruction of reports of Reportable Incidents	**Conduct by a custodian intended to impede the reporting or investigation of a reportable incident.**	
	Unlawful use/ administration of a controlled substance	**Any illegal administration, use, or distribution by a custodian of a controlled substance (e.g. codeine, OxyContin, Ambien, cocaine) while in the workplace or on duty.**	
	Aversive Conditioning	**The use of unpleasant physical stimulus to modify behavior. ANY use of aversive conditioning is prohibited in facilities under the jurisdiction of OMH.**	
OMH & JC Death **Report to JC & OMH**	**OMH licensed or operated Inpatient Units, Residential Programs, or CPEP**	**Clients in OMH licensed or operated Inpatient Units, Residential Programs, or CPEP. Additionally, deaths of clients who had received services from such programs in the 30 day period preceding death. These "Death of Client" incidents are reported to the Justice Center.**	**Report to JC & OMH** 1. Call JC Death Reporting Line at 1-855-373-2124 to make initial report. The VPCR report will appear in your JC Import List in NIMRS. 2. Import the VPCR report into a NIMRS Incident, enter required information on each NIMRS screen and click "Email OMH". 3. Submit ***Report of Death to the Justice Center*** by clicking "Email JC" within 5 days of the initial report to the JC.
OMH Only Death **Report to OMH**	**OMH licensed or operated OUTPATIENT programs**	**Death of patients receiving services only from an OMH licensed or operated OUTPATIENT program, must be reported to OMH via NIMRS. Additionally, deaths of clients who had received services from such programs in the 30 day period preceding death. These "Death of Client" incidents are entered directly into NIMRS using the "New Incident" button on the NIMRS Home Page.**	**Report ONLY to OMH** 1. Log into NIMRS & select "New Incident" from the home screen. 2. Bypass the "pop-up" window by clicking on the "x" in the right corner. 3. Enter required information on each NIMRS screen and click "Email OMH".

* In some cases definitions are abbreviated. The revised 14 NYCRR Part 524 contains full incident definitions.

** Meets definition of Significant Incident reportable to JC and OMH only when resulting in serious injury or harm.

OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTABILITY

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

Incident Type – Sub Type		Definition	Required Reporting
Significant Incident Regardless of Harm	**Significant Incident:** The following incidents are **Significant Incidents**, reportable to the Justice Center and OMH, when they **occur on program premises** or when the patient was **under the actual or intended supervision** of a custodian:		
	Crime	**An event which is or appears to be a crime under New York State or Federal law which 1) involves a patient as a victim, or 2) which affects or has the potential to affect the health or safety of one or more patients of the program or 3) has the potential to have a significant adverse impact on the property or operation of the program.**	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WI/ 2. **Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Queue in NIMRS. The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and "close" report in NIMRS within 45 days.
	Financial Exploitation	**The use, appropriation, or misappropriation by a custodian of a patient's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources.**	
	Fire Setting	**Action by a patient, either deliberate or accidental, that results in fire on program premises.**	
	Injury of Unknown Origin*	**Any suspicious injury to a patient for which a cause cannot be immediately determined.**	
	Missing patient (Inpatient/Residential)	**A patient of an inpatient or residential program who has not been accounted for when expected to be present (in accordance with facility or program practice or policies) and who has not been found on the facility grounds or other expected location, or who is known to have left the facility grounds without the permission of an employee, when such permission is otherwise required or a patient of an outpatient program who is under the age of 18, and whose whereabouts is not accounted for when expected to be present or under the supervision of an employee.**	
	Mistreatment: – Unauthorized Restraint or Seclusion	**Unauthorized use of restraint or seclusion that is inappropriate because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable state or federal regulations, but which does not rise to the level of abuse (i.e. physical abuse or Deliberate Inappropriate Use of Restraint.**	
	– Inappropriate use of time out	**Use of time out to remove a patient from regular programming and isolate him/her in an area for the convenience of a custodian or as a substitute for programming**	
	– Intentional Improper Administration of medication	**Intentional administration to a patient of a prescription drug or over-the-counter medication which is not in substantial compliance with a prescription.**	
	Sexual Assault	**A sexual attack including but not limited to those that result in vaginal, anal, or oral penetration, i.e., rape or attempted rape and sodomy or attempted sodomy; and/or any sexual contact between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years of age or older and a person who is less than 17 years old, or which involves a patient who is deemed incapable of consent.**	
	Sexual Contact Between Children	**Vaginal, anal, or oral penetration by patients under age 18 that occurs in a setting where the patient receives around-the-clock care or on the premises of an outpatient program.**	
	Suicide Attempt	**An act committed by a patient of a mental health provider in an effort to cause his or her own death.**	
	Wrongful Conduct	**Actions or inactions on the part of the custodian that are contrary to sound judgment or training and which are related to the provision of services, the safeguarding of patient health, safety or welfare, or patient rights, but which do not meet the definition of abuse or neglect.**	

* In some cases definitions are abbreviated. The revised 14 NYCRR Part 524 contains full incident definitions.

** Meets definition of Significant Incident reportable to JC and OMH only when resulting in serious injury or harm.

OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTABILITY

NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

Incident Type – Sub Type		Definition	Required Reporting
Significant Incidents Only with Serious Injury or Harm	**Significant Incident Only with Serious Injury or Harm:** The following incidents are **Significant Incidents**, reportable to the Justice Center and OMH, when they **occur on program premises** or when the patient was **under the actual or intended supervision** of a custodian with **serious injury or harm involved**:		
	Adverse Drug Reaction**	**Unintended, unexpected, or excessive response to a medication given at normal doses, which results in transfer to ER or serious injury or harm.**	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WI/ 2. **Report to OMH:** After the report is made to the JC, the VPCR report will appear in your JC Import Queue in NIMRS. The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and "close" report in NIMRS within 45 days.
	Assault**	**A violent or forceful physical attack by a person other than a custodian, in which a patient is either the victim or aggressor, and which results in serious injury or harm.**	
	Falls by Patients**	**Events where patients trip, slip or otherwise fall in an inpatient or residential setting, resulting in serious injury or harm**	
	Fights**	**A physical altercation between two or more patients, in which there is no clear aggressor and no clear victim, resulting in serious injury or harm**	
	Medication Error**	**An error in prescribing, dispensing, or administering a drug which results in serious injury or harm.**	
	Other Incident**	**An event, other than those identified above, which has or creates a risk of, an adverse effect on the life, health, or safety of a patient.**	
	Self-Abuse**	**Self-inflicted injury not intended to result in death that results in serious injury or harm.**	
	Verbal Aggression by Patients**	**A sustained, repetitive action or pattern by a patient or patients of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another patient or patients, which causes serious injury or harm.**	
OMH Only Incidents **Report Only to OMH**	**OMH INCIDENTS: The following off-site incidents are reportable ONLY to OMH**		**Report ONLY to OMH** 1. Log into NIMRS & select "New Incident" from the home screen. 2. A "pop-up" with info on the reporting process will be displayed. Click "x" to bypass. 3. Enter required information on each NIMRS screen and click "Email OMH".
	Crime in the Community	**An event which is, or appears to be, a crime under New York State or Federal law, and which is perceived to be a significant danger to the community or which involves a patient whose behavior poses an imminent concern to the community.**	
	Missing Subject of AOT Court Order	**A client who is subject to an AOT court order who fails to keep a scheduled appointment and/or who cannot be located within a 24 hour period (Outpatient Only) Inpatient and residential programs should report missing AOT persons under "Missing Client".**	
	Suicide Attempt, Off-site	**An act committed by a patient of a mental health provider in an effort to cause his or her own death that occurs off program premises or when the patient was not under the actual or intended supervision of a custodian.**	

****Serious Injury or Harm:** physical harm requiring medical treatment or intervention beyond first aid (excluding routine diagnostic tests such as laboratory work, X-rays, or scans if no medical treatment is provided); psychological harm evidenced by negative changes in affect, behavior, cognition, or which necessitate a significant change in psychotropic or therapeutic intervention; or, a risk for life threatening physical injury or for psychiatric emergency or trauma.

PLEASE CALL NIMRS HELPDESK (518) 474-3619 FOR ANY INQUIRIES RELATING TO REPORTING AN INCIDENT

* In some cases definitions are abbreviated. The revised 14 NYCRR Part 524 contains full incident definitions.

** Meets definition of Significant Incident reportable to JC and OMH only when resulting in serious injury or harm.

Unity House of Cayuga County Inc.
OASAS Guide for Incident Management

Reportable Incidents - Occur under the auspices of the agency. Reported to the Justice Center for Certified Programs. All reportable incidents are reported to OASAS, Exec. Dir, and MHLS.	
Abuse/Neglect	
Physical Abuse	Conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury by means of slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting, corporal punishment, etc.
Sexual Abuse	Any sexual contact between an individual receiving services and a custodian of the program; whether or not the contact would constitute a crime.
Psychological Abuse	Conduct by a custodian intentionally or recklessly causing, by verbal or non-verbal conduct, a substantial diminution of a service recipient's emotional, social or behavioral development or condition, supported by a clinical assessment performed by a clinician. Such conduct may include but is not limited to intimidation, threats, the display of a weapon or other object that could reasonably be preceived to inflict pain or injury, taunts, derogatory comments or ridicule.
Deliberate Inappropriate Use of Restraints	Use of restraint deliberately inconsistent with an individual's plan. Restraint will include manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person to freely move his or her arms, legs or body.
Use of Aversive Conditioning	Application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person. I.e.. Noxious odors, noxious tastes, blindfolds, withholding of meals, food in an unpalatable form.
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; suppressing the reporting of the incident to the VPCR; intentionally making a false statement or intentionally withholding information; intentional failure of a supervisor to act on a report per the regulations; for a custodian, failing to report a reportable incident upon discovery.
Unlawful Use or Administration of a Controlled Substance	Administration by a custodian to a service recipient of a controlled substance without a prescription, or other medication not approved for any use by the FFDA. Also includes a custodian unlawfully using or distributing a controlled substance at the workplace or while on duty.
Neglect	The 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 impairment of the physical, mental, or emotional condition of a service recipient. This shall include: Failure to provide proper supervision that results in conduct between persons receiving services that would constitute abuse if committed by a custodian; Failure to provide adequate food, clothing, shelter, or medical, dental, optometric or surgical care; Failure to provide educational entitlements. Staff impaired by alcohol/drugs would also constitute abuse.

Unity House of Cayuga County Inc.
OASAS Guide for Incident Management

Significant Incidents - Reportable to the JC, OASAS and Exec Dir. Because of the severity of the situation 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.	
Conduct Between Individuals Receiving Services	Conduct between persons receiving services, which if committed by a custodian, would constitute abuse.
Unauthorized Seclusion	Placement of an individual in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will.
Unauthorized Use of Time-Out	A person is removed from regular programming and isolated in a room or area for the convenience of a custodian, or as a substitute for programming; but shall not include the use of a time-out as an emergency intervention to protect the health or safety of the individual or other persons.
Medication Error with Adverse Effect	The administration of a prescribed or over-the-counter medication, which is inconsistent with a prescription or order, which has an adverse effect on an individual receiving services. Adverse effect: the unanticipated and undesirable side effect from the
Inappropriate Use of Restraints	The use of a restraint when the technique that is used, the amount of force used, or the situation in which the restraint is used is inconsistent with an individual's plan of service and/or generally accepted treatment practices and/or applicable laws and regulations.
Crime	An event that is, or appears to be, a crime under NYS or Federal law involving custodians, clients, including children of service recipients in a residential program, or others as victims or perpetrators.
Body Cavity Search	Must be with client consent.
Violation of Confidentiality	Pursuant to 42 CFR part 2 or the HIPAA.
Death	Any death of a current client (or within 30 days of the client's discharge).
Missing Client	If the service recipient has not been accounted for when and where such client is expected to be present and, after 24 hours, whose location has not been determined by means of immediate and appropriate diligent efforts. *A missing client could be the result of NEGLECT, if the service recipient required 24/7 staff supervision and the client's whereabouts is unknown because of staff failure to supervise. A missing client is NOT a service recipient who leaves against medical advice or is administratively discharged or who chooses to leave treatment and makes his/her choice known. Providers should always take responsible action, pursuant to program policy and considering confidentiality, to reach out to a service recipient's emergency contact to verify the person's safety.*

Unity House of Cayuga County Inc.
OASAS Guide for Incident Management

Suicide Attempt	Whether or not preceded by statement of intent; statement of intent alone is not a suicde attempt; statements of intent should be recorded in a patient's clinical record.
Children residing in programs with parents in treatment	Any incidents involving children in a program are reportable. Incidents involving children may require multiple notifications (SCR, police, court/probation, etc.)

Reportable Incidents to OASAS (not JC) and appropriate internal agency notification.

Physical Plant issues leading to incidents	e.g. Door not properly latched, which allows someone on the roof who committed suicide.
Lack of food/ nutrition	
Inadequate Supervision resulting in an incident	e.g. Leading to drug use, violence, sex, etc.
Inappropriate relationships between staff and client	e.g. becoming facebook friends, special favors, exchanging phone numbers or texting, dating, taking client to their home.
Overdose	Service recipient overdose is suspected or the the person was found unresponsive ***(This becomes reportable to the JC if the overdose may be due to staff failure to screen for contraband, do a room check or monitor night security.)***
Any ER visit	For injury requiring more than First Aid. Identify triage and treatment. ***(This becomes reportable if the action or inaction of staff contributed to a medical event - ie. Known heart condiction and failure to provide medication; patient's repeated complaints of abdominal pain and staff failure to consider appendicitis or; patient admitted with a toothache which is not addressed and becomes infected.)***
Any First Responder called to a certified site	Includes police and fire dept if 1) there any injuries or harm as a result, 2) was there lack of supervision from staff? Or 3) was there any faulty equipment?
Fire setting	Client action resulting in fire, either deliberate or accidental.