Proposed New Rule – December 5, 2012

5123:2-17-02 Addressing major unusual incidents and unusual incidents to ensure continuous quality improvement.

(A) Purpose

This rule establishes the requirements for addressing major unusual incidents and unusual incidents and implements a continuous quality improvement process in order to prevent or reduce the risk of harm to individuals.

(B) Application

This rule applies to county boards, developmental centers, and providers.

(C) Definitions

(1) "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 future occurrences. There are three administrative investigation procedures (category A, category B, and category C) that correspond to the three categories of major unusual incidents.

(2) "Agency provider" means a provider, certified or licensed by the department or a provider approved by the Ohio office of medical assistance to provide services under the transitions developmental disabilities waiver, that employs staff to deliver services to individuals and who may subcontract the delivery of services. "Agency provider" includes a county board while providing specialized services.

(3) "At-risk individual" means an individual whose health or safety is adversely affected or whose health or safety may reasonably be considered to be in danger of being adversely affected.

(4) "Chosen representative" means an adult family member or other person providing support and guidance to an individual in accordance with section 5126.043 of the Revised Code.

(5) "County board" means a county board of developmental disabilities as established under Chapter 5126. of the Revised Code or a regional council of governments as established under Chapter 167. of the Revised Code when it includes at least one county board.

(6) "Department" means the Ohio department of developmental disabilities.

(7) "Developmental center" means an intermediate care facility under the managing responsibility of the department.

(8) "Developmental disabilities employee" means any of the following:

(a) An employee of the department;

(b) An employee of a county board;

(c) An employee of an agency provider in a position that includes providing specialized services to an individual; or

(d) An independent provider.

(9) "Intermediate care facility for individuals with intellectual disabilities" (or "intermediate care facility") means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medicaid program by the director of health in accordance with Title XIX of the Social Security Act, 79 Stat. 286 (1965), 42 U.S.C. 1396.

(10) "Incident tracking system" means the department's on-line system for reporting major unusual incidents.

(11) "Independent provider" means a self-employed person who provides services for which he or she must be certified under rule 5123:2-2-01 of the Administrative Code or approved by the Ohio office of medical assistance and does not employ, either directly or through contract, anyone else to provide the services.

(12) "Individual" means a person with a developmental disability.

(13) "Individual served" means an individual who receives specialized services.

(14) "Investigative agent" means an employee of a county board or a person under contract with a county board who is certified by the department to conduct investigations of major unusual incidents.

(15) "Major unusual incident" means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or safety 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 service delivery system or will be receiving such services as a result of the incident. There are three categories of major unusual incidents that correspond to three administrative investigation procedures delineated in appendix A, appendix B, and appendix C to this rule:

(a) Category A

(i) Death. "Death" means the death of an individual.

(ii) Exploitation. "Exploitation" means the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit, or gain.

(iii) Failure to report. "Failure to report" means that a person, who is required to report pursuant to section 5123.61 of the Revised Code, 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 safety 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 the department. Pursuant to division (C)(1) of section 5123.61 of the Revised Code, such report shall be made to the department and the county board when the incident involves an act or omission of an employee of a county board.

(iv) Misappropriation. "Misappropriation" means depriving, defrauding, or otherwise obtaining the real or personal property of an individual by any means prohibited by the Revised Code, including Chapters 2911. and 2913. of the Revised Code.

(v) Neglect. "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 or safety of the individual.

(vi) Peer-to-peer act. "Peer-to-peer act" means one of the following incidents involving two individuals served:

(a) Exploitation which means intentionally depriving another individual of real or personal property in the amount of twenty dollars or more or improperly using an individual or an individual's resources for monetary or personal benefit, profit, or gain.

(b) Physical act that occurs when an individual is targeting, or firmly fixed on another individual and the act is not accidental or random. The incident 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 shall be considered major unusual incidents. Minor injuries such as scratches or reddened areas shall be considered unusual incidents and shall require immediate action, a review to uncover possible cause/contributing factors, and prevention measures.

(c) Sexual act which means sexual conduct and/or contact for the purposes of sexual gratification without the consent of the other individual.

(d) Verbal act which means the use of words, gestures, or other communicative means to purposefully threaten, coerce, or intimidate the other individual when there is the opportunity and ability to carry out the threat.

(vii) Physical abuse. "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 section 2901.01 of the Revised Code. Such force may include, but is not limited to, hitting, slapping, pushing, or throwing objects at an individual.

(viii) Prohibited sexual relations. "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 at the time of the incident and includes persons in the developmental disabilities employee's supervisory chain of command.

(ix) Rights code violation. "Rights code violation" means any violation of the rights enumerated in section 5123.62 of the Revised Code that creates a likely risk of harm to the health or safety of an individual.

(x) Sexual abuse. "Sexual abuse" means unlawful sexual conduct or sexual contact as those terms are defined in section 2907.01 of the Revised Code and the commission of any act prohibited by section 2907.09 of the Revised Code (e.g., public indecency, importuning, and voyeurism).

(xi) Verbal abuse. "Verbal abuse" means using words, gestures, or other communicative means to purposefully threaten, coerce, intimidate, harass, or humiliate an individual.

(b) Category B

(i) Attempted suicide. "Attempted suicide" means a physical attempt by an individual that results in emergency room treatment, in-patient observation, or hospital admission.

(ii) Medical emergency. "Medical emergency" means an incident where emergency medical intervention is required to save an individual's life (e.g., Heimlich maneuver and related choke relief techniques such as back blows or cardiopulmonary resuscitation, "Epi-Pen" usage, or intravenous for dehydration).

(iii) Missing individual. "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 or pose an imminent risk of harm to self or others.

(iv) Significant injury. "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 incident tracking system as either known or unknown.

(c) Category C

(i) Law enforcement. "Law enforcement" means any incident that results in the

individual served being charged, incarcerated, or arrested.

(ii) Unapproved behavior support. "Unapproved behavior support" means the use of any aversive strategy or intervention prohibited by paragraph (J) of rule 5123:2-1-02 of the Administrative Code 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 safety. An intervention that is prohibited by paragraph (J) of rule 5123:2-1-02 of the Administrative Code and does not pose a likely risk to health and safety shall be investigated as an unusual incident.

(iii) Unscheduled hospitalization. "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.

(16) "Primary person involved" means the person alleged to have committed or to have been responsible for the physical abuse, sexual abuse, verbal abuse, exploitation, failure to report, misappropriation, neglect, prohibited sexual relations, rights code violation, or death.

(17) "Provider" means any agency provider or independent provider that provides specialized services.

(18) "Qualified intellectual disability professional" has the same meaning as in 42 C.F.R. 483.430 (2012).

(19) "Specialized services" means any program or service designed and operated to serve primarily individuals, including a program or service provided by an entity licensed or certified by the department.

(20) "Unusual incident" includes, but is not limited to: dental injuries; falls; an injury that is not a significant injury; medication errors; overnight relocation of an individual due to a fire, natural disaster, or mechanical failure; an incident involving two individuals served that is not a peer-to-peer act major unusual incident; and unapproved behavior supports without a likely risk to health and safety.

(21) "Working day" means Monday, Tuesday, Wednesday, Thursday, or Friday except when that day is a holiday as defined in section 1.14 of the Revised Code.

(D) Major unusual incidents

(1) 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:

(i) Death;

(ii) Exploitation;

(iii) Law enforcement;

(iv) Misappropriation;

(v) Neglect;

(vi) Physical abuse;

(vii) Prohibited sexual relations;

(viii) Sexual abuse; and

(ix) 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:

(i) Attempted suicide;

(ii) Failure to report;

(iii) Medical emergency;

(iv) Missing individual;

(v) Peer-to-peer act;

(vi) Rights code violation;

(vii) Significant injury;

(viii) Unapproved behavior support; and

(ix) Unscheduled hospitalization.

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

(a) Immediate and ongoing medical attention, as appropriate;

(b) 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

(c) Other necessary measures to protect the health and safety of at-risk individuals.

(3) Immediately upon receipt of a report or notification of an allegation, the county board shall:

(a) Ensure that all reasonable measures necessary to protect the health and safety of any at-risk individual have been taken;

(b) Determine if additional measures are needed; and

(c) Notify the department if the circumstances in paragraph (D)(14) of this rule that require a department-directed investigation are present. Such notification shall take place on the first working day the county board becomes aware of the incident.

(4) The provider or county board staff shall immediately, but no later than four hours after discovery of the incident, notify the county board through means identified by the county board of the following incidents or allegations:

(a) Death.

(b) Exploitation.

(c) Misappropriation.

(d) Neglect.

(e) Physical abuse.

(f) Sexual abuse.

(g) Verbal abuse.

(h) When the provider has received inquiries from the media regarding a major unusual incident.

(5) 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. 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 the department.

(6) The county board shall enter preliminary information regarding the incident in the incident tracking system and in the manner prescribed by the department by three

p.m. on the working day following notification by the provider or of becoming aware of the major unusual incident.

(7) When a provider has placed an employee on leave or otherwise taken protective action pending the outcome of the investigation, the county board or department, 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 safety of any at-risk individuals. The provider shall notify the county board or department, as applicable, of any changes regarding the protective action.

(8) If the provider is a developmental center, all reports required by this rule shall be made directly to the department.

(9) The county board shall have a system that is available twenty-four hours a day, seven days a 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.

(10) Reporting of alleged criminal acts

(a) Nothing in this rule relieves mandatory reporters of the responsibility to report abuse, neglect, misappropriation, and/or exploitation pursuant to section 5123.61 of the Revised Code.

(b) 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 C.F.R. 483.420(d)(2).

(c) The provider or county board shall immediately report to the law enforcement entity having jurisdiction of the location where the incident occurred, any allegation of physical abuse, sexual abuse, verbal abuse, misappropriation, exploitation, neglect, or peer-to-peer act which may constitute a criminal act. The county board shall ensure that the notification has been made.

(d) The department shall immediately report to the Ohio state highway patrol, any allegation of physical abuse, sexual abuse, verbal abuse, misappropriation, exploitation, neglect, or peer-to-peer act occurring at a developmental center which may constitute a criminal act.

(11) Abused or neglected children

All allegations of abuse or neglect as defined in sections 2151.03 and 2151.031 of

the Revised Code of an individual under the age of twenty-one 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.

(12) Notification requirements

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

(i) Guardian or chosen representative or other person whom the individual has identified.

(ii) Service and support administrator serving the individual.

(iii) Licensed or certified residential provider.

(iv) Staff or family living at the individual's residence who have responsibility for the individual's care.

(v) 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/guardians in a peer-to-peer act unless such notification would jeopardize the health and safety 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, the department 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 safety of any at-risk individual. The notified provider or county board shall take such steps necessary to address the health and safety needs of any at-risk individual and may consult the department in this regard. The department 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 the department

when they are aware that the primary person involved works for another provider.

(13) General 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 the department in accordance with rule 5123:2-5-07 of the Administrative Code. Developmental center investigators are considered certified investigative agents for the purpose of this rule.

(b) All major unusual incidents require an investigation meeting the applicable investigation procedure requirements established in appendix A, appendix B, or appendix C to this rule unless it is not possible or relevant to the investigation to meet a requirement under this rule, in which case the reason shall be documented. Investigations shall be conducted and reviewed by investigative agents.

(i) The department or county board may elect to follow the investigation procedure for category A major unusual incidents for any major unusual incident.

(ii) Based on the facts discovered during 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 investigation procedure shall be used to conduct the major unusual incident investigation.

(iii) Major unusual incidents that involve an active criminal investigation may be closed as soon as the county board ensures that the major unusual incident is properly coded, cause and contributing factors are determined, a finding is made, and prevention measures 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 incident tracking system, fulfilling category C 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 rule. If a requirement cannot be met, the investigative agent shall document that the requirement cannot be met and the reasons therefore.

(e) Except when law enforcement or the public children's services agency has been notified and is considering conducting an investigation, the county board shall immediately, but no later than twenty-four hours after the discovery of any major unusual incident, commence and document the initiation of the investigation. If law enforcement or the public children's services agency notifies the county board that it has declined to investigate, the county board shall commence the investigation within twenty-four hours of such notification. "Commencing an investigation" means any of the actions defined as such in appendix A to this rule.

(f) The county board shall commence an investigation within a reasonable amount of time based upon the initial information received or obtained and consistent with the health and safety of all at-risk individuals, but no later than three working days from notification or identification by the county board.

(g) If the provider is an intermediate care facility, the intermediate care facility shall meet all applicable federal regulations, including 42 C.F.R. 483.420 (2012).

(h) An intermediate care facility is required to conduct an investigation regardless of where an incident involving a resident of the intermediate care facility occurs. If the major unusual incident involves an individual who resides in an intermediate care facility, including a developmental center, and the incident occurs at a program operated by a county board, it is the responsibility of the intermediate care facility to complete an investigation and assure that the investigation complies with federal guidelines. The investigative agent may utilize information from the intermediate care facility's investigation to meet the requirements of this rule or conduct a separate investigation. Copies of the full investigation shall be provided to the intermediate care facility and the county board. All requirements in this rule shall be met. The department shall resolve any conflicts that arise.

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

(j) All developmental disabilities employees shall cooperate with administrative investigations conducted by entities authorized to conduct investigations. Providers and county boards shall respond to requests for information within the timeframe requested. The timeframes identified shall be reasonable.

(k) The investigative agent shall complete a report of the investigation and submit it

for closure in the incident tracking system within thirty working days unless the department grants an extension.

(l) The report shall follow the format prescribed by the department. 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 findings and conclusions.

(m) The county board may request extensions of the time period for submission of the report. The department shall grant such extensions for good cause. If an extension is granted, the department may require submission of interim reports and may identify alternative actions to assist with the timely conclusion of the report.

(14) Department-directed investigations

(a) The department shall conduct the administrative investigation when the major unusual incident includes an allegation against:

(i) The superintendent of a county board or developmental center.

(ii) The executive director or equivalent of a regional council of governments.

(iii) 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.

(iv) An investigative agent.

(v) A service and support administrator.

(vi) A major unusual incident contact or designee employed by a county board.

(vii) A current member of a county board.

(viii) A person having any known relationship with any of the persons specified in paragraphs (D)(14)(a)(i) to (D)(14)(a)(vii) of this rule when such relationship may present a conflict of interest or the appearance of a conflict of interest.

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

(b) A department-directed investigation or investigation review may be conducted following the receipt of a request from a county board, developmental center, provider, individual, or guardian if the department determines that there is a

reasonable basis for the request.

(c) The department may conduct a review or investigation of any major unusual incident or may request that a review or investigation be conducted by another county board, a regional council of governments, or any other governmental entity authorized to conduct an investigation.

(15) Written summaries

(a) No later than five working days following the county board's, developmental center's, or department's recommendation via the incident tracking system that the report be closed, the county board, developmental center, or department shall provide a written summary of the investigation of each category A or category B major unusual incident, including the allegations, the facts and findings, including as applicable, whether the case was substantiated or unsubstantiated, and preventive measures implemented in response to the incident to:

(i) The individual, individual's guardian, or individual's chosen representative, as applicable; in the case of a peer-to-peer act, both individuals/guardians shall receive the written summary;

(ii) The licensed or certified provider and provider at the time of the incident; and

(iii) The service and support administrator serving the individual or other person selected by the individual to coordinate services for the individual.

(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 summary 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 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/insufficient evidence, or unsubstantiated/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, individual's chosen representative, 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 the department if the department conducted the investigation, within fifteen calendar days following receipt of the finding. An individual may receive assistance from any person selected by the individual to prepare a letter 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 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 the department within fifteen calendar days of the county board determination. The director will issue a decision within thirty calendar days.

(16) 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 reoccurrence 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 incident. The team members shall jointly determine what constitutes reasonable steps necessary to prevent the reoccurrence 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) The department may review reports submitted by a county board or developmental center. The department may obtain additional information necessary to consider the report, including copies of all investigation reports that have been prepared. Such additional information shall be provided within the time period specified by the department.

(d) The department shall review and close reports regarding major unusual incidents listed below:

(i) Death.

(ii) Exploitation.

(iii) Failure to report.

(iv) Misappropriation.

(v) Missing individual.

(vi) Neglect.

(vii) Peer-to-peer act.

(viii) Physical abuse.

(ix) Prohibited sexual relations.

(x) Rights code violation.

(xi) Sexual abuse.

(xii) Significant injury when cause is unknown.

(xiii) Unapproved behavior support.

(xiv) Verbal abuse.

(xv) Any major unusual incident that is the subject of a director's alert.

(xvi) Any major unusual incident investigated by the department.

(e) The county board shall review and close reports regarding major unusual incidents listed below:

(i) Attempted suicide.

(ii) Law enforcement.

(iii) Medical emergency.

(iv) Significant injury when cause is known.

(v) Unscheduled hospitalization.

(f) The department may review any case to ensure it has been properly closed and shall conduct sample reviews to ensure proper closure by the county board. The department may reopen any investigation that does not meet requirements of this rule. The county board shall provide any information deemed necessary by the department to close the case.

(g) The department and the county board shall consider the following criteria when determining whether to close a case:

(i) Whether sufficient reasonable measures have been taken to ensure the health and safety of any at-risk individual;

(ii) Whether a thorough investigation has been conducted consistent with the standards set forth in this rule;

(iii) Whether the team, including the county board and provider, collaborated on developing preventive measures to address the causes and contributing

factors;

(iv) That the county board has ensured that the preventive measures have been implemented to prevent reoccurrence;

(v) Whether the incident is part of a pattern or trend as flagged through the incident tracking system requiring some additional action; and

(vi) Whether all requirements set forth in statute or rule have been satisfied.

(17) Analysis of major unusual incident trends and patterns

(a) All providers, including county boards as providers, shall send the county board a semi-annual and annual report regarding major unusual incident trends and patterns. The county board shall semi-annually review all providers for major unusual incident trends and patterns. The semi-annual review shall be cumulative for the first two quarters and include an in-depth analysis. The annual review shall be cumulative for all four quarters and include an in-depth analysis.

(b) All reviews and analyses shall be completed within thirty calendar days following the end of the six-month period. The semi-annual and annual analyses shall contain the following elements:

(i) Date of review;

(ii) Name of person completing review;

(iii) Time period of review;

(iv) Comparison of data for previous three years;

(v) Explanation of data;

(vi) Data for review by major unusual incident category type;

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

(viii) Specific trends by residence, region, or program;

(ix) Previously identified trends and patterns; and

(x) Action plans and preventive measures to address noted trends and patterns.

(c) County boards shall conduct the analysis and follow-up for all entities operated by county boards such as workshops, schools, transportation. The county board shall send its analysis and follow-up actions to the department by August

thirty-first for the semi-annual review and by February twenty-eighth for the annual review.

(d) Each agency provider shall send its analysis and follow-up actions to the county board for all programs operated in the county by August thirty-first for the semi-annual review and by February twenty-eighth for the annual review. The county board shall keep the analysis and follow-up actions on file and make them available to the department upon request.

(e) The county board and department shall review the analysis to ensure that all issues have been reasonably addressed to prevent reoccurrence.

(f) The county board shall ensure that trends and patterns of major unusual incidents are included and addressed in the affected individual's service plan.

(g) Each county board or as applicable, each council of governments to which the county board belongs, shall have a committee that reviews trends and patterns of major unusual incidents. The committee shall be made up of a reasonable representation of the county board(s), providers, families, and other stakeholders deemed appropriate by the committee.

(h) The role of the 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 trends, patterns, or areas for improving the quality of life for individuals supported in the county or counties.

(i) The committee shall meet each September to review and analyze data for the first six months of the calendar year and each March to review and analyze data for the preceding calendar year. The county board or council of governments shall send the aggregate data prepared for the meeting to all participants ten calendar days in advance of the meeting.

(j) The county board or council of governments shall record and maintain minutes of each meeting, distribute the minutes to members of the committee, and make the minutes available to any person upon request.

(k) The county board shall ensure follow-up actions identified by the committee have been implemented.

(l) The department shall prepare a report on trends and patterns identified through the process of reviewing major unusual incidents. The department shall periodically, but at least semi-annually, review this report with a committee appointed by the director of the department which shall consist of at least six members who represent various stakeholder groups, including disability rights Ohio and the Ohio office of medical assistance. The committee shall make recommendations to the department regarding whether appropriate actions to ensure the health and safety of individuals served have been taken. The committee may request that the department obtain additional information as may

be necessary to make recommendations.

(E) Unusual incidents

(1) Unusual incidents shall be reported and investigated by the provider of service.

(2) Each agency provider shall develop and implement a policy and procedure that:

(a) Identifies what is to be reported as an unusual incident which shall include unusual incidents as defined by this rule;

(b) Requires anyone who becomes aware of an unusual incident to report it to the person designated by the provider who can initiate proper action;

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

(d) Requires the provider to investigate unusual incidents, identify the cause and contributing factors when applicable, and develop preventive measures .

(3) The agency provider shall ensure that all staff are trained and knowledgeable regarding the policy and procedure.

(4) 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 contracts, the county board or contract entity shall notify the licensed provider or staff, guardian, or chosen representative, as applicable, at the individual's residence. The notification shall be made the same day that the incident is discovered.

(5) Independent providers shall complete an incident report, notify the individual's guardian or chosen representative, as applicable, and forward the incident report to the service and support administrator or county board designee on the day an unusual incident is discovered.

(6) Each agency 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.

(7) The unusual incident reports, documentation of identified trends and patterns, and corrective action shall be made available to the county board and department upon request.

(8) Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but not be limited to, the name of the individual, a brief description of the incident, any injuries, time, date, location, and preventive measures.

(9) The agency provider and the county board shall ensure that trends and patterns of unusual incidents are included and addressed in each individual's service plan.

(F) Oversight

(1) The county board 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 developed, and that trends and patterns have been identified and addressed in accordance with this rule. The sample shall be made available to the department for review upon request.

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

(3) The department shall conduct reviews of county boards and providers as necessary to ensure the health and safety of individuals and compliance with the requirements of this rule. Failure to comply with the requirements of this rule may be considered by the department in any regulatory capacity, including certification, licensure, and accreditation.

(G) Access to records

(1) Reports made under section 5123.61 of the Revised Code and this rule are not public records as defined in section 149.43 of the Revised Code. Records may be provided to parties authorized to receive them in accordance with sections 5123.613 and 5126.044 of the Revised Code, to any governmental entity authorized to investigate the circumstances of the alleged abuse or neglect, misappropriation, or exploitation and to any party to the extent that release of a record is necessary for the health or safety of an individual.

(2) A county board shall not review, copy, or include in any report required by this rule personnel records of an employee that are confidential under state or federal statutes or rules, including medical and insurance records, workers' compensation records, employment eligibility verification (I-9) forms, and social security numbers.

(3) A county board may review and copy personnel records prepared in connection with the provider's daily operations, such as training records, timesheets, and work schedules.

(4) Upon the department's request, the provider shall provide to the department copies of personnel records that are not confidential.

(5) The provider may redact any confidential information contained in a record as identified in paragraph (G)(2) of this rule before the copies are provided to the county board or the department.

(6) Any party entitled to receive a report required by this rule may waive receipt of the

report. Any waiver of receipt of a report shall be made in writing.

(H) Training

(1) All agency providers and county boards shall ensure their staff are trained on the requirements of this rule prior to direct contact with any individual. Thereafter, all employees shall receive annual training on the requirements of this rule including a review of health and safety alerts issued by the department since the previous year's training.

(2) All independent providers shall follow the requirements for initial training on the provisions of this rule in accordance with rule 5123:2-2-01 of the Administrative Code and shall receive annual training on the requirements of this rule including a review of health and safety alerts issued by the department since the previous year's training.

(3) All agency providers and county boards shall ensure that all staff responsible for administrative compliance with this rule are trained on the requirements of this rule no later than ninety calendar days from the time of employment and each calendar year thereafter. The training shall include a review of health and safety alerts issued by the department since the previous year's training.

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APPENDIX A

CATEGORY A
MAJOR UNSUAL INCIDENTS
INVESTIGATION PROCEDURE

Findings in investigations of major unusual incidents in category A shall be based upon a preponderance of the evidence standard. "Preponderance of evidence" means that credible evidence indicates that it is more probable than not that the incident occurred. There are three possible findings of a category A investigation:

1. "Substantiated" means there is a preponderance of evidence that the alleged incident occurred.

2. "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.

3. "Unsubstantiated/unfounded" means the allegations are 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

1. Commence the investigation immediately, or no later than twenty-four hours after discovery of the incident. "Commencing the investigation" means any of the following:
   a. Interviewing the reporter of the incident.
   b. Gathering relevant documents such as nursing notes, progress notes, or incident report.
   c. 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 investigation.
   d. Initiating interviews with witnesses or victims.
2. Interview the victim no later than three 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 investigation.
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. 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 the 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. Note 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 direct witnesses to the incident and document the interviews.
8. Gather written statements from all relevant witnesses. Alternative methods include a statement written by the investigator using the individual's words and/or videotaping the individual's statement.
9. 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. Include a description of treatment received or ordered. Qualified medical professionals include, but are not limited to, physicians, nurses, emergency medical technicians, and therapists.
10. Interview others who may have relevant information and provide documentation of each interview.
11. Conduct follow-up interviews if needed.
12. Include a clear statement of the allegation.
13. Evaluate all witnesses and documentary evidence in a clear, complete, and non-ambiguous manner.
14. Evaluate the relative credibility of the witnesses. Factors to be considered in judging the credibility of a witness include:
    a. 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 leave out or not know about information that he/she should know about?);
    b. Whether the witness was in a position to hear or see what is claimed;
    c. Whether the witness has a history of being reliable and honest when reporting incidents or making statements regarding incidents;
    d. Whether the witness has a special interest or motive for making a false statement (e.g., is there a possible bias of the witness?);
    e. The relevant disciplinary history of the primary person involved, such as involvement in similar past allegations;
    f. The witness's demeanor during the interview (e.g., did the witness appear evasive or not forthcoming?); and
    g. Whether the witness did other things that might affect his/her credibility.
15. Include a succinct and well-reasoned analysis of the evidence.
16. Include a clearly stated conclusion that identifies which allegations were and were not substantiated.

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Incident Specific Requirements – Death

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

Incident Specific Requirements – Exploitation or Misappropriation

1. 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.
2. Document the depriving, defrauding, or otherwise obtaining the real or personal property of an individual by means prohibited by the Revised Code. Include any indication of the intent of the primary person involved.
3. Describe any items taken from the individual or anything received by the primary person involved as a result of the exploitation or misappropriation.
4. Gather copies of all financial records related to the incident, including cancelled checks.
5. Document the time, date, and officer's name (for law enforcement agency notification).
6. Include any indication that the individual may have consented or not consented to the taking of his/her property or to the exploitation.
7. Verify that the property belonged to the individual.
8. Provide a description of how the improper act occurred.
9. Obtain the outcome of a criminal case, if resolved.

Incident Specific Requirements – Failure to Report

1. Provide a statement indicating the abuse, neglect, or misappropriation the primary person involved did not report, including when and how it occurred.
2. Provide a statement indicating that the primary person involved was aware of the abuse, neglect, or misappropriation, including when and how the primary person involved became aware of the abuse, neglect, or misappropriation.
3. Provide a statement of how the failure to report the abuse, neglect, 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.
4. 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.
5. Provide a written description of any injury.
6. Provide an explanation from the primary person involved of why he/she failed to report.
7. Provide a statement of any reasons or circumstances explaining the failure to report by the primary person involved.

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Incident Specific Requirements – Neglect

1. Verify and document the duty of the primary person involved to provide care to the individual.
2. 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.
3. 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 others to the primary person involved, statements made by the primary person involved, or training received by the primary person involved.
4. Verify that the action or inaction of the primary person involved resulted in, or reasonably could have resulted in, harm to the individual.
5. Specifically describe the harm or any risk of harm to the individual caused by the action or inaction by the primary person involved.

Incident Specific Requirements – Peer-to-Peer Act

1. Verify and document that the proper supervision and supports were provided to all individuals.
2. Ensure the proper coding of the major unusual incident.
3. Describe the act in detail.
4. Document all of the individuals' involved histories and the history, if any, between the individuals.
5. Describe what preceded the incident and what action was taken at the time and immediately after the incident. Document attempts to notify the guardian prior to interviewing the individual.

Incident Specific Requirements – Physical Abuse

1. 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.
2. Provide a description of the individual's reaction to the physical force used. This may include, but is not limited to, the individual fell backwards or individual's head or other body part jerked backward and any other indication of pain or discomfort by the individual which may include words, vocalizations, or body movements.
3. Include comments made during the incident by the primary person involved.
4. Document how the harm to the individual is linked to the physical force used by the primary person involved.

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Incident Specific Requirements – Prohibited Sexual Relations

1. Describe and document the type of sexual conduct or contact.
2. 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.)
3. Verify and document that the primary person involved was providing paid care to the individual.
4. Verify and document that the primary person involved was not married to the individual.
5. 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.

Incident Specific Requirements – Rights Code Violation

1. Indicate the specific right(s) 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.
2. Describe the harm or risk of harm caused to the individual as a result of the rights code violation by the primary person involved.

Incident Specific Requirements – Sexual Abuse

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

Incident Specific Requirements – Verbal Abuse

1. 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.
2. Provide a description of the reaction of the individual to the words or gestures, including any words or vocalizations.
3. Describe the volume used, including such description as loud, soft, and tone of voice, and

where the primary person involved was located in relation to the individual.

4. Describe the past history of verbal interactions between the primary person involved and the individual.

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APPENDIX B

CATEGORY B
MAJOR UNSUAL INCIDENTS
INVESTIGATION PROCEDURE

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 behavior support documentation.

3. Interview witnesses as necessary to determine the cause or resolve conflicting information.

4. Interview others with relevant information as necessary.

5. Maintain a summary of each interview conducted.

6. Identify the causes and any contributing factors to the incident.

7. Review past related incidents as appropriate, including but not limited to, prior immediate health and safety measures taken and other preventive measures.

8. Verify that the preventive measures have been implemented.

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APPENDIX C

CATEGORY C
MAJOR UNSUAL INCIDENTS
INVESTIGATION PROCEDURE

The following information shall be collected for major unusual incidents in Category C. The investigative agent shall review the information to ensure that the information is complete and the major unusual incident is properly coded. Information collected does not take the place of an incident report.

Incident Specific Requirements – Law Enforcement

1. Provide name, title, and phone number of person reporting to the county board.
2. Provide prior history of law enforcement involvement.
3. Describe individual's activities prior to the incident (e.g., followed normal routine, no problems, or increased agitation).
4. Individual's supervision level?
5. Was the supervision level met?
6. Describe immediate actions taken to ensure health and safety (e.g., alerting jail of medical concerns, dietary restrictions, ensuring medications are available to individual).
7. Describe the incident in detail.
8. Describe injuries, if any, to the individual or to the individual's victim.
9. Outcome of court hearing.
10. Identify cause and contributing factors.
11. Prevention planning.

Incident Specific Requirements – Unapproved Behavior Support

1. Provide name, title, and phone number of person reporting to the county board.
2. Does the individual have a behavior support plan?
3. Describe what happened prior to the incident; develop a timeline.
4. Description of the intervention used.
5. Was the individual injured? Was excessive force used?
6. List the health and safety risk.
7. How long did the unapproved behavior support last?
8. Were other measures taken first? If so, list these measures.
9. Identify cause and contributing factors.
10. Prevention planning.

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Incident Specific Requirements – Unscheduled Hospitalization

1. Provide name, title, and phone number of person who reported to the county board.
2. Provide list of documents reviewed.
3. Address individual's medical history (e.g., recent similar illnesses, chronic/acute conditions).
4. Describe individual's health during prior seventy-two hours.
5. Were the symptoms addressed in a timely manner? If not, why?
6. Describe incident.
7. Diagnosis and discharge summary.
8. Follow-up appointment.
9. Identify cause and contributing factors.
10. If individual had the flu or pneumonia, had he or she received a flu shot or pneumonia vaccine?
11. Prevention planning.