- This training will cover the following:
  - Background on the NYS Justice Center
  - Definitions
  - Reporting Requirements
  - Assessment

BACKGROUND

BACKGROUND

- For too long our state has been inconsistent in how it addressed incidents of abuse against people with special needs, lacking any real consistent standards for tracking and investigating complaints or punishing those who commit abuse and neglect.

- Knowing that it is imperative that state government meet its obligation to protect and serve all New Yorkers, Governor Cuomo proposed legislation to create the Justice Center for the Protection of People with Special Needs to give New York State the strongest standards and practices in the nation for protecting people with special needs and disabilities.

BACKGROUND

- Tens of thousands of New Yorkers, including advocates and families of people with special needs, came together to support this crucial legislation, which was passed by the State Legislature on June 20, 2012.
- This legislation will standardize regulation of multiple agencies within New York State.
- The Justice Center for the Protection of People with Special Needs will transform how our state protects over one million New Yorkers under the care or jurisdiction of six state agencies.

VOLUNTARY AGENCIES

- Voluntary Providers Certified by OPWDD
- Quality Assurance Departments
  - Regulations that govern are found in Part 624 (revised) and Part 625 (new regulations)
  - NYS Social Service Law, Article 11 Protection of People with Special Needs

  www.opwdd.ny.gov/opwdd_resources/incident_management/home

WHAT DOES THE JUSTICE CENTER PROVIDE?

- **24/7 Hotline to Report Abuse:** The Justice Center operates an around-the-clock hotline that immediately classifies the allegations and routes reports to law enforcement agencies, when appropriate.
- **Comprehensive Database:** The Justice Center created a comprehensive statewide abuse database to track and monitor abuse complaints in order to spot trends.
- **Statewide Abuse Register:** The Justice Center created a register of workers who have committed serious acts of abuse who will be prohibited from ever being hired again in any position where they would work with people with disabilities or special needs.
- **Consolidation of Background Checks:** The Justice Center reviews and evaluates the criminal history for individuals applying for a job or other position dealing with people with special needs and disabilities.

WHAT DOES THE JUSTICE CENTER PROVIDE OPWDD AGENCIES?

- **Code of Conduct:** All individuals working with people with special needs and disabilities are required to sign and are held accountable to a code of basic ethical standards.
- **Special Prosecutor:** The Justice Center has a special prosecutor who will investigate and prosecute allegations of abuse and serious neglect that rise to the level of criminal offenses as well as a team of investigators and lawyers.
- **Standardized Definitions for Abuse and Neglect:** The Governor's legislation created standardized definitions of abuse and neglect regarding children and adults in covered facilities and programs to enable the Justice Center to more easily process and address instances of abuse.
- **Strengthened Anti-Abuse Laws:** The legislation increased criminal penalties for endangering the welfare of people with disabilities and special needs, and strengthens a prosecutor's ability to prove that any of these individuals in a facility operated, licensed or certified by the State was a victim of sexual abuse.

CODES OF CONDUCT

- The Justice Center adopted a Code of Conduct for all custodians, defined as anyone who has **regular and substantial** contact with individuals receiving services from an entity subject to the Justice Center's jurisdiction.
- Governs the conduct of custodians in areas of safety, dignity, respect, community inclusion and protection.
- Custodians are required to sign a document acknowledging they have read and understand the Code, promise to abide by it, and also pledge to report incidents involving individuals receiving services.

MANDATED REPORTER

What type of information should a mandated reporter be prepared to provide to the Justice Center?

- Details regarding the victim(s), suspect(s), and witnesses(s).
- Details of the incident, including the date and time, location, description of incident and injury/impact to the victim.
- State agency responsible for oversight of the agency, facility and/or program
- Name and address of the agency, facility and/or program
- Confirmation that immediate protections are in place for the victim(s), if applicable.
- Any other information that may assist with the investigation or review of an incident.

When is reporting required?

- 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.

MANDATED REPORTING OF INCIDENTS PROCESS

- First, as always, **immediately intervene** and **STOP** the abuse.
  - Ensure persons safety
- **ALL Eyewitnesses** and **anyone** with knowledge must report incidents
  - EXAMPLE: If 4 people witness an incident
    - Contact immediate supervisor or next level of supervision
    - All 4 staff must then notify the JC individually via a call or web form

IN SUMMARY…

- Effective June 30th certain incidents must be reported to the Justice Center
- The Justice Center is the second largest law enforcement agency in NYS.
- Every original witness of a Reportable Incident, Abuse, Neglect, or significant incident must be called into the JC Hotline.
- All staff must sign the JC Code of Conduct
- JC requirements are additional reporting requirements, along with the agency's reporting procedures:
  - Notify Direct Supervisor or next level of supervision
  - Contact CSDD QA
  - Contact JC Hotline
  - Contact OPWDD

DEFINITIONS

4 COMPONENTS OF INCIDENT MANAGEMENT

OBSERVING:
Knowing and understanding what constitute an incident and what to look for and what to report

REPORTING:
Knowing how to report an incident, including what format, when to report, and whom to report to

INVESTIGATING:
Knowing and completing the proper procedures for conducting a thorough investigation

REVIEWING:
Developing and implementing any actions as a result of the outcome of the incident and investigation

REGULATION

- NYS Regulation Part 624
- NYS Regulation Part 625

- Reportable Incidents of Abuse and Neglect
- Significant Incidents
- Serious Notable Occurrences
- Minor Notable Occurrences

PART 624

Reportable incidents are events or situations that meet the definitions in eight categories as follows:

PHYSICAL ABUSE

- shall mean conduct by a custodian intentionally or recklessly causing, by physical contact, physical injury or serious or protracted impairment of the physical, mental, or emotional condition of the individual receiving services, or causing the likelihood of such injury or impairment. Such conduct may include, but shall not be limited to: **slapping, hitting, kicking, biting, choking, smothering, shoving, dragging, throwing, punching, shaking, burning, cutting**, or the use of **corporal punishment.**
- **Physical abuse shall not include reasonable emergency interventions necessary to protect the safety of any party.**

SEXUAL ABUSE

1. any conduct by a custodian that subjects a person receiving services to any offense defined in article 130 or section 255.25, 255.26, or 255.27 of the penal law, or any conduct or communication by such custodian that allows, permits, uses, or encourages a person receiving services to engage in any act described in articles 230 or 263 of the penal law.
2. any sexual contact between an individual receiving services and a custodian of the program or facility which provides services to that individual whether or not the sexual contact would constitute a crime (see especially section 130.05(i) of the penal law). However, if the individual receiving services is married to the custodian the sexual contact shall not be considered sexual abuse. Further, for purposes of this subparagraph only, a person with a developmental disability who is or was receiving services and is also an employee or volunteer of an agency shall not be considered a custodian if he or she has sexual contact with another individual receiving services who is a consenting adult who has consented to such contact.

PSYCHOLOGICAL ABUSE

- includes any verbal or nonverbal conduct that may cause significant emotional distress to an individual receiving services.

1. Examples include, but are not limited to, taunts, derogatory comments or ridicule, intimidation, threats, or the display of a weapon or other object that could reasonably be perceived by an individual receiving services as a means for infliction of pain or injury, in a manner that constitutes a threat of physical pain or injury.
2. In order for a case of psychological abuse to be substantiated after it has been reported, the conduct must be shown to intentionally or recklessly cause, or be likely to cause, a **substantial diminution of the emotional, social or behavioral development or condition of the individual receiving services.** Evidence of such an effect must be supported by a clinical assessment performed by a physician, psychologist, psychiatric nurse practitioner, licensed clinical or master social worker or licensed mental health counselor.

DELIBERATE INAPPROPRIATE USE OF RESTRAINTS

- shall mean the use of a restraint when the technique that is used, the amount of force that is used, or the situation in which the restraint is used is deliberately inconsistent with an individual's plan of services (e.g. individualized service plan (ISP) or a habilitation plan), or behavior support plan, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, except when the restraint is used as a reasonable emergency intervention to prevent imminent risk of harm to a person receiving services or to any other party. For purposes of this paragraph, a restraint shall include the use of any manual, pharmacological, or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body.

USE OF AVERSIVE CONDITIONING

- shall mean the application of a physical stimulus that is intended to induce pain or discomfort in order to modify or change the behavior of a person receiving services. Aversive conditioning may include, but is not limited to, the use of physical stimuli such as noxious odors, noxious tastes, blindfolds, and the withholding of meals and the provision of substitute foods in an unpalatable form. The use of aversive conditioning is prohibited by OPWDD.

OBSTRUCTION OF REPORTS OF REPORTABLE INCIDENTS

- shall mean conduct by a custodian that impedes the discovery, reporting, or investigation of the treatment of a service recipient by falsifying records related to the safety, treatment, or supervision of an individual receiving services; actively persuading a custodian or other mandated reporter (as defined in section 488 of the Social Services Law) from making a report of a reportable incident to the statewide vulnerable persons' central register (VPCR) or OPWDD with the intent to suppress the reporting of the investigation of such incident; intentionally making a false statement, or intentionally withholding material information during an investigation into such a report; intentional failure of a supervisor or manager to act upon such a report in accordance with OPWDD regulations, policies or procedures; or, for a custodian, failing to report a reportable incident upon discovery.

UNLAWFUL USE OR ADMINISTRATION OF A CONTROLLED SUBSTANCE

- shall mean any administration by a custodian to a service recipient of a controlled substance as defined by article 33 of the public health law, without a prescription, or other medication not approved for any use by the federal food and drug administration. It also shall include a custodian unlawfully using or distributing a controlled substance as defined by article 33 of the public health law, at the workplace or while on duty.

NEGLECT

- shall mean any action, inaction, or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental, or emotional condition of a service recipient. Neglect shall include, but is not limited to:

1. failure to provide proper supervision, including a lack of proper supervision **that results in** conduct between persons receiving services that would constitute abuse as described in paragraphs (1) through (7) of this subdivision if committed by a custodian;
2. failure to provide adequate food, clothing, shelter, or medical, dental, optometric or surgical care, consistent with Parts 633, 635, and 686, of this Title (and 42 CFR Part 483, applicable to Intermediate Care Facilities), and provided that the agency has reasonable access to the provision of such services and that necessary consents to any such medical, dental, optometric, or surgical treatment have been sought and obtained from the appropriate parties; or
3. failure to provide access to educational instruction, by a custodian with a duty to ensure that an individual receives access to such instruction in accordance with the provisions of part one of article 65 of the education law and/or the individual's individualized education program.

Significant incident shall mean an incident, other than an incident of abuse or neglect, that because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services.

CONDUCT BETWEEN PERSONS RECEIVING SERVICES THAT WOULD CONSTITUTE ABUSE

- as described in paragraphs (1) through (7) of this subdivision if committed by a custodian, except sexual activity involving adults who are capable of consenting and consent to the activity

SECLUSION AND TIME OUT

- generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and which impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services, including but not limited to:

1. ***seclusion***, which shall mean the placement of an individual receiving services in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will. OPWDD prohibits the use of seclusion
2. ***unauthorized use of time-out***, which (for the purposes of this clause only) shall mean the use of a procedure in which a person receiving services is removed from regular programming and isolated in a room or area for the convenience of a custodian, or as a substitute for programming;

MEDICATION ERROR WITH ADVERSE EFFECT

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

INAPPROPRIATE USE OF RESTRAINTS

- ***inappropriate use of restraints***, which shall mean the use of a restraint when the technique that is used, the amount of force that is used, or the situation in which the restraint is used is inconsistent with an individual's plan of services (including a behavior support plan), generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies. For the purposes of this subdivision, a "restraint" shall include the use of any manual, pharmacological or mechanical measure or device to immobilize or limit the ability of a person receiving services to freely move his or her arms, legs or body

MISSING PERSON

- the **unexpected absence** of an individual receiving services that based on the person's history and current condition **exposes him or her to risk of injury**
  - Example
    - *A person has **no community** time due to a rights limitation or lack of skills/ability to be in the community.*
    - There is risk to others in the community, i.e. person has offended others.
    - There is risk to themselves, i.e. person lacks self-preservation skills.
    - This is an unexpected absence and based on the person's history and condition, exposes them or others to be at risk of injury.

CHOKING, WITH KNOWN RISK

- which shall mean partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, that leads to a partial or complete inability to breathe, involving an individual with a known risk for choking and a written directive addressing that risk

SELF-ABUSIVE BEHAVIOR, WITH INJURY

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

CONDUCT BETWEEN PERSONS RECEIVING SERVICES

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

OTHER MISTREATMENT

- Conduct on the part of a custodian, that is inconsistent with the individual's plan of services, generally accepted treatment practices, and/or applicable federal or state laws, regulations or policies, and which impairs or creates a reasonably foreseeable potential to impair the health, safety, or welfare of an individual receiving services.

Notable occurrences are events or situations that meet the definitions that follow **and** occur under the auspices of an agency.

Notable occurrences shall not include events and situations which meet the definition of a Reportable Incident(Abuse, Neglect, or Serious). An exception is that deaths that also meet the definition of a reportable incident shall be reported both as the reportable incident and as a notable occurrence.

INJURY

Minor	Serious
Any suspected or confirmed harm, hurt, or damage to an individual receiving services, caused by an act of that individual or another, whether or not by accident, and whether or not the cause can be identified, which results in an individual requiring medical or dental treatment by a physician, dentist, physician's assistant, or nurse practitioner, and such treatment is more than first aid. Illness in itself shall not be reported as an injury or any other type of incident or occurrence.	Any injury that results in the admission of a person to a hospital for treatment or observation because of injury.

UNAUTHORIZED ABSENCE

Serious

The unexpected or unauthorized absence of a person after formal search procedures have been initiated by the agency. Reasoned judgments, taking into consideration the person's habits, deficits, capabilities, health problems, etc., shall determine when formal search procedures need to be implemented. It is required that formal search procedures must be initiated immediately upon discovery of an absence involving a person whose absence constitutes a recognized potential danger to the wellbeing of the person or others. Any unauthorized absence event is considered a **serious notable occurrence**.

Example

*A person **has community time** but didn't return when they said they would.*

The absence is unexpected.

The absence for the period of time could potentially be a danger to their wellbeing or others wellbeing.

DEATH

Serious

The death of any person receiving services, regardless of the cause of death, is a **serious notable occurrence**. This includes all deaths of individuals who live in residential facilities operated or certified by OPWDD and other deaths that occur under the auspices of an agency.

CHOKING, WITH NO KNOWN RISK

Serious

For the purposes of this paragraph, partial or complete blockage of the upper airway by an inhaled or swallowed foreign body, including food, that leads to a partial or complete inability to breathe, other than a *"reportable" choking, with known risk*, incident, involving an individual with a known risk for choking and a written directive addressing that risk. Any choking with no known risk event is considered a **serious notable occurrence**.

THEFT AND FINANCIAL EXPLOITATION

Minor	Serious
Any suspected theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation, involving values of more than $15.00 and less than or equal to $100.00, that does not involve a credit, debit, or public benefit card, and that is an isolated event.	Any suspected theft of a service recipient's personal property (including personal funds or belongings) or financial exploitation, involving a value of more than $100.00; theft involving a service recipient's credit, debit, or public benefit card (regardless of the amount involved); or a pattern of theft or financial exploitation involving the property of one or more individuals receiving services.

SENSITIVE SITUATIONS

Serious

Those situations involving a person receiving services that do not meet the criteria of Reportable Incidents or other notable occurrences, which may be of a delicate nature to the agency, and which are reported to ensure awareness of the circumstances. Sensitive situations shall be defined in agency policies and procedures, and shall include, but not be limited to, possible criminal acts committed by an individual receiving services. Sensitive situations are serious notable occurrences.

ICF VIOLATIONS

Serious

Events and situations concerning residents of Intermediate Care Facilities (ICFs) that are identified as violations in federal regulation applicable to ICFs and do not meet the definitions of reportable incidents as specified in section 624.3 of this Part or other notable occurrences as specified in this section

NOTE: Community Services does not operate any ICFs.

Plans of Action

Preventative Measures

- ❑ Increased supervision of individual(s)
- ❑ Training for individual(s)
- ❑ Revise individual service plan
- ❑ Make environmental modifications
- ❑ Further training for all staff

Corrective Measures

- ❑ Employee returns to work
- ❑ Employee trained further
- ❑ Increased employee supervision
- ❑ Employee corrective action
- ❑ Employee reassigned
- ❑ Employee terminated

- Events and Situations

PART 625

PART 625 REGULATIONS

- OPWDD added a new Part 625 to its regulations.
- Part 625 applies to Events/Situations which are not under the auspices of the agency.
- If an event/situation occurs in a facility subject to the oversight of another state agency; school, hospital, doctor's office… This must be documented and reported to the facility if it rises to the level of an incident in Part 624.
- Events not under the auspices of the agency… These are not "Incidents" but rather "events."
- Events that do not occur under the auspices of CSDD will be subject to Part 625.

DEFINITIONS OF 625 EVENTS AND SITUATIONS

Physical Abuse	The non-accidental use of force that results in bodily injury, pain or impairment, including but not limited to, being slapped, burned, cut, bruised or improperly physically restrained.
Sexual Abuse	Non-consensual sexual contact of any kind, including but not limited to, forcing sexual contact or forcing sex with a third party.
Emotional Abuse	The willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other abusive conduct, including but not limited to, frightening or isolating an adult.
Active Neglect	The willful failure by the caregiver to fulfill the care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.
Passive Neglect	The non-willful failure of a caregiver to fulfill care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services.

DEFINITIONS OF 625 EVENTS AND SITUATIONS

Self-Neglect	An adult's inability, due to physical and/or mental impairments, to perform tasks essential to caring for oneself, including but not limited to, providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety; or managing financial affairs.
Financial Exploitation	The use of an adult's funds, property, or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers, or denial of access to assets.
Death	The end of life, expected or unexpected, regardless of cause.

INTERVENTIONS AND ACTIONS MUST BE TAKEN FOR ALL EVENTS/SITUATIONS

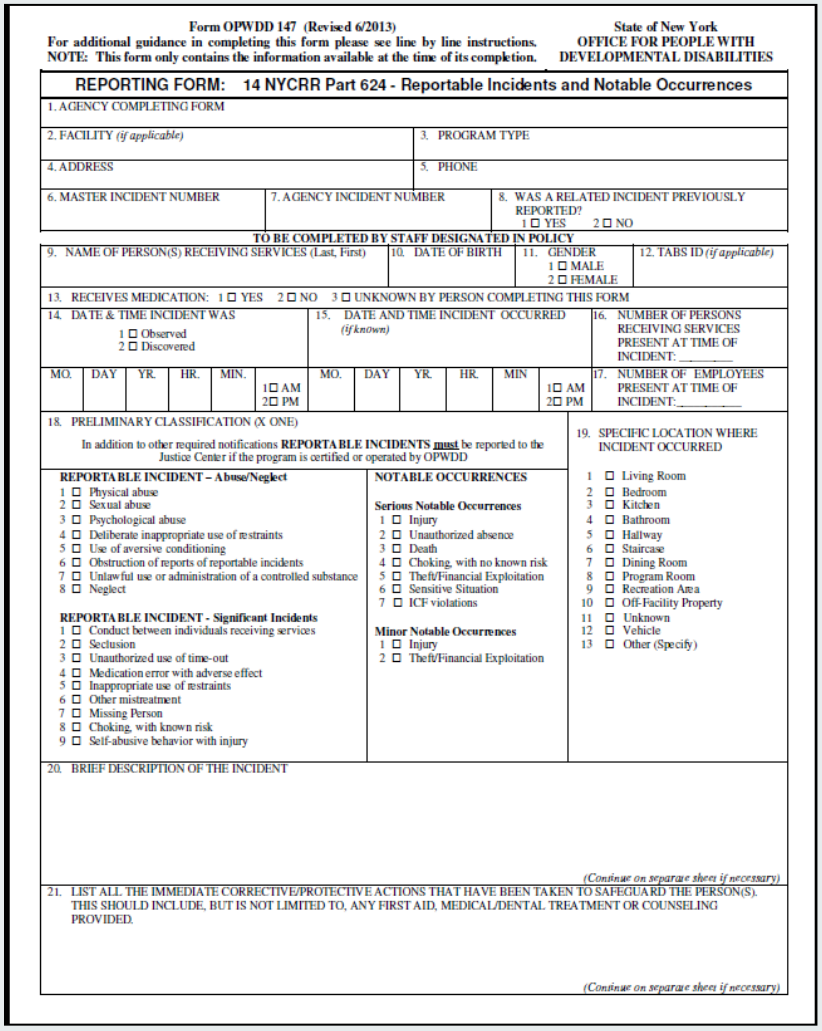
Interventions include

- ❑ Notifications to family, APS, CPS, law enforcement, etc…
- ❑ Hospital
- ❑ School

Actions Include

- ❑ Assessing and monitoring the individual
- ❑ Educating the individual about choices/options
- ❑ Interview involved individuals and/or witnesses
- ❑ Offering to make referral to appropriate service provider
- ❑ Review records and other relevant documentation.

THE FORMS



Form OPWDD 147 (Revised 6/2013)
For additional guidance in completing this form please see line by line instructions.
NOTE: This form only contains the information available at the time of its completion.

State of New York
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

REPORTING FORM: 14 NYCRR Part 624 - Reportable Incidents and Notable Occurrences

1. AGENCY COMPLETING FORM

2. FACILITY *(if applicable)* | 3. PROGRAM TYPE

4. ADDRESS | 5. PHONE

6. MASTER INCIDENT NUMBER | 7. AGENCY INCIDENT NUMBER | 8. WAS A RELATED INCIDENT PREVIOUSLY REPORTED? 1 ☐ YES 2 ☐ NO

TO BE COMPLETED BY STAFF DESIGNATED IN POLICY

9. NAME OF PERSON(S) RECEIVING SERVICES (Last, First) | 10. DATE OF BIRTH | 11. GENDER 1 ☐ MALE 2 ☐ FEMALE | 12. TABS ID *(if applicable)*

13. RECEIVES MEDICATION: 1 ☐ YES 2 ☐ NO 3 ☐ UNKNOWN BY PERSON COMPLETING THIS FORM

14. DATE & TIME INCIDENT WAS 1 ☐ Observed 2 ☐ Discovered

15. DATE AND TIME INCIDENT OCCURRED *(if known)*

16. NUMBER OF PERSONS RECEIVING SERVICES PRESENT AT TIME OF INCIDENT: _____

MO.	DAY	YR.	HR.	MIN.	1☐ AM 2☐ PM	MO.	DAY	YR.	HR.	MIN	1☐ AM 2☐ PM

17. NUMBER OF EMPLOYEES PRESENT AT TIME OF INCIDENT: _____

18. PRELIMINARY CLASSIFICATION (X ONE)

In addition to other required notifications **REPORTABLE INCIDENTS must** be reported to the Justice Center if the program is certified or operated by OPWDD

REPORTABLE INCIDENT – Abuse/Neglect
1 ☐ Physical abuse
2 ☐ Sexual abuse
3 ☐ Psychological abuse
4 ☐ Deliberate inappropriate use of restraints
5 ☐ Use of aversive conditioning
6 ☐ Obstruction of reports of reportable incidents
7 ☐ Unlawful use or administration of a controlled substance
8 ☐ Neglect

REPORTABLE INCIDENT - Significant Incidents
1 ☐ Conduct between individuals receiving services
2 ☐ Seclusion
3 ☐ Unauthorized use of time-out
4 ☐ Medication error with adverse effect
5 ☐ Inappropriate use of restraints
6 ☐ Other mistreatment
7 ☐ Missing Person
8 ☐ Choking, with known risk
9 ☐ Self-abusive behavior with injury

NOTABLE OCCURRENCES

Serious Notable Occurrences
1 ☐ Injury
2 ☐ Unauthorized absence
3 ☐ Death
4 ☐ Choking, with no known risk
5 ☐ Theft/Financial Exploitation
6 ☐ Sensitive Situation
7 ☐ ICF violations

Minor Notable Occurrences
1 ☐ Injury
2 ☐ Theft/Financial Exploitation

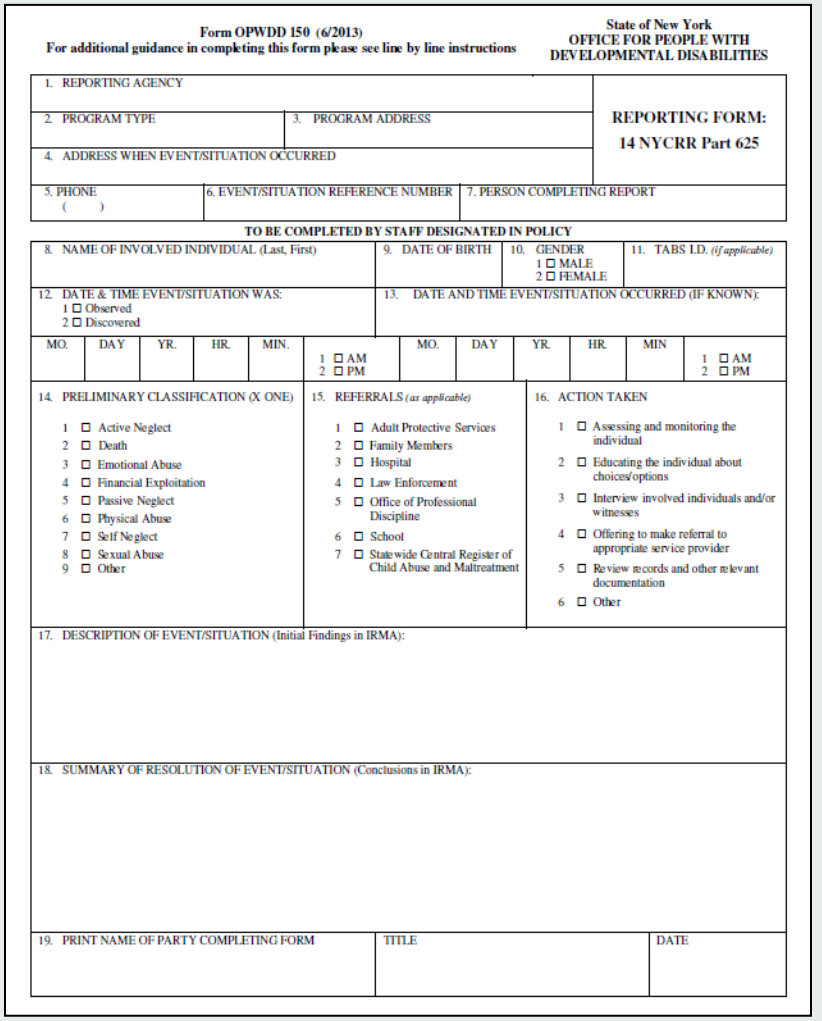
19. SPECIFIC LOCATION WHERE INCIDENT OCCURRED
1 ☐ Living Room
2 ☐ Bedroom
3 ☐ Kitchen
4 ☐ Bathroom
5 ☐ Hallway
6 ☐ Staircase
7 ☐ Dining Room
8 ☐ Program Room
9 ☐ Recreation Area
10 ☐ Off-Facility Property
11 ☐ Unknown
12 ☐ Vehicle
13 ☐ Other (Specify)

20. BRIEF DESCRIPTION OF THE INCIDENT

(Continue on separate sheet if necessary)

21. LIST ALL THE IMMEDIATE CORRECTIVE/PROTECTIVE ACTIONS THAT HAVE BEEN TAKEN TO SAFEGUARD THE PERSON(S). THIS SHOULD INCLUDE, BUT IS NOT LIMITED TO, ANY FIRST AID, MEDICAL/DENTAL TREATMENT OR COUNSELING PROVIDED.

(Continue on separate sheet if necessary)



Form OPWDD 150 (6/2013)
For additional guidance in completing this form please see line by line instructions

State of New York
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

1. REPORTING AGENCY

2. PROGRAM TYPE | 3. PROGRAM ADDRESS

4. ADDRESS WHEN EVENT/SITUATION OCCURRED

REPORTING FORM: 14 NYCRR Part 625

5. PHONE ( ) | 6. EVENT/SITUATION REFERENCE NUMBER | 7. PERSON COMPLETING REPORT

TO BE COMPLETED BY STAFF DESIGNATED IN POLICY

8. NAME OF INVOLVED INDIVIDUAL (Last, First) | 9. DATE OF BIRTH | 10. GENDER 1 ☐ MALE 2 ☐ FEMALE | 11. TABS I.D. *(if applicable)*

12. DATE & TIME EVENT/SITUATION WAS: 1 ☐ Observed 2 ☐ Discovered

13. DATE AND TIME EVENT/SITUATION OCCURRED (IF KNOWN):

MO.	DAY	YR.	HR.	MIN.	1 ☐ AM 2 ☐ PM	MO.	DAY	YR.	HR.	MIN	1 ☐ AM 2 ☐ PM

14. PRELIMINARY CLASSIFICATION (X ONE)
1 ☐ Active Neglect
2 ☐ Death
3 ☐ Emotional Abuse
4 ☐ Financial Exploitation
5 ☐ Passive Neglect
6 ☐ Physical Abuse
7 ☐ Self Neglect
8 ☐ Sexual Abuse
9 ☐ Other

15. REFERRALS *(as applicable)*
1 ☐ Adult Protective Services
2 ☐ Family Members
3 ☐ Hospital
4 ☐ Law Enforcement
5 ☐ Office of Professional Discipline
6 ☐ School
7 ☐ Statewide Central Register of Child Abuse and Maltreatment

16. ACTION TAKEN
1 ☐ Assessing and monitoring the individual
2 ☐ Educating the individual about choices/options
3 ☐ Interview involved individuals and/or witnesses
4 ☐ Offering to make referral to appropriate service provider
5 ☐ Review records and other relevant documentation
6 ☐ Other

17. DESCRIPTION OF EVENT/SITUATION (Initial Findings in IRMA):

18. SUMMARY OF RESOLUTION OF EVENT/SITUATION (Conclusions in IRMA):

19. PRINT NAME OF PARTY COMPLETING FORM | TITLE | DATE

NOTIFICATION OF INCIDENTS AND INFORMATION SHARING

JUSTICE CENTER

All Justice Center Notifications can be made by:

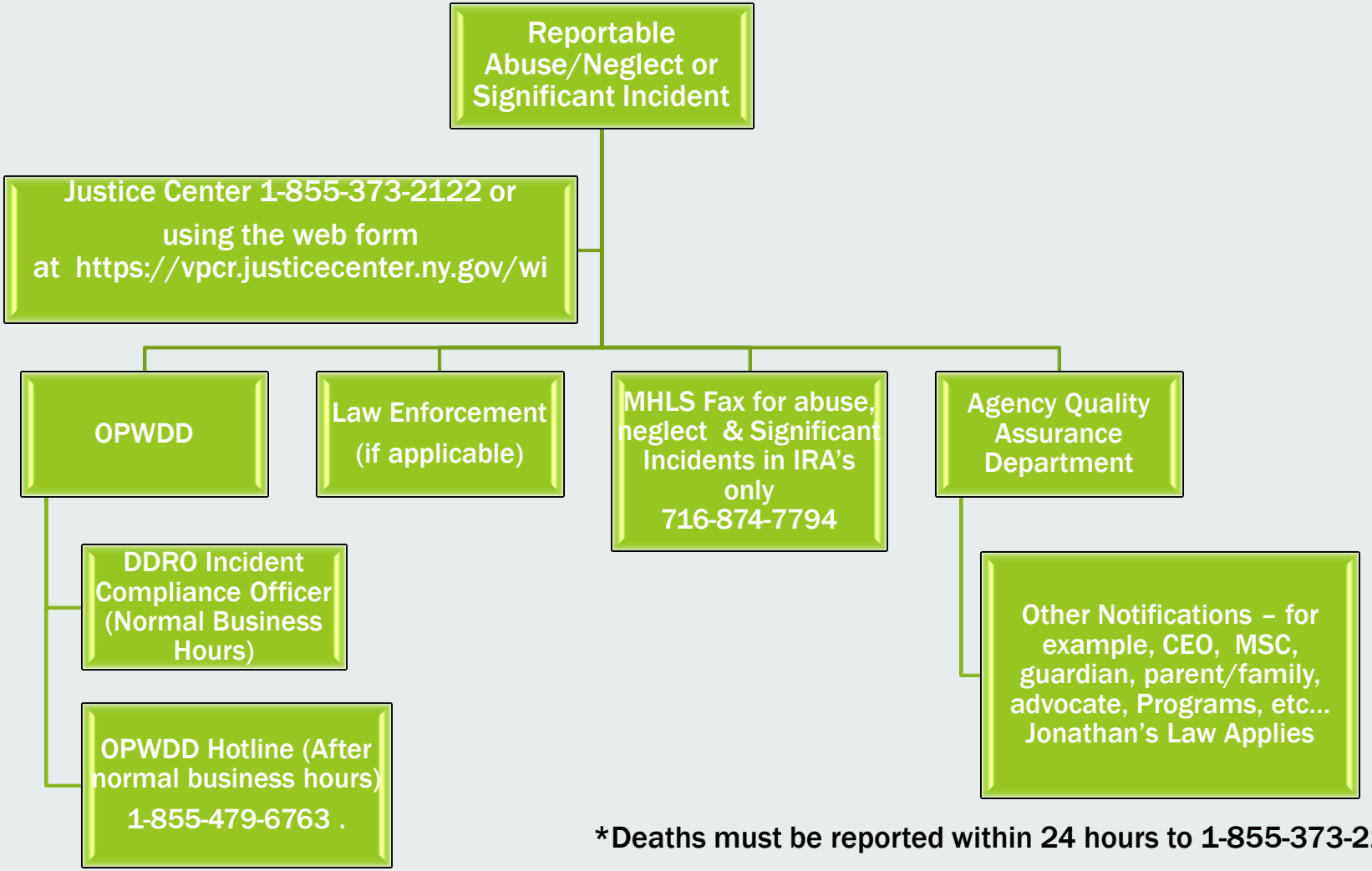
Calling

1-855-373-2122

Webform

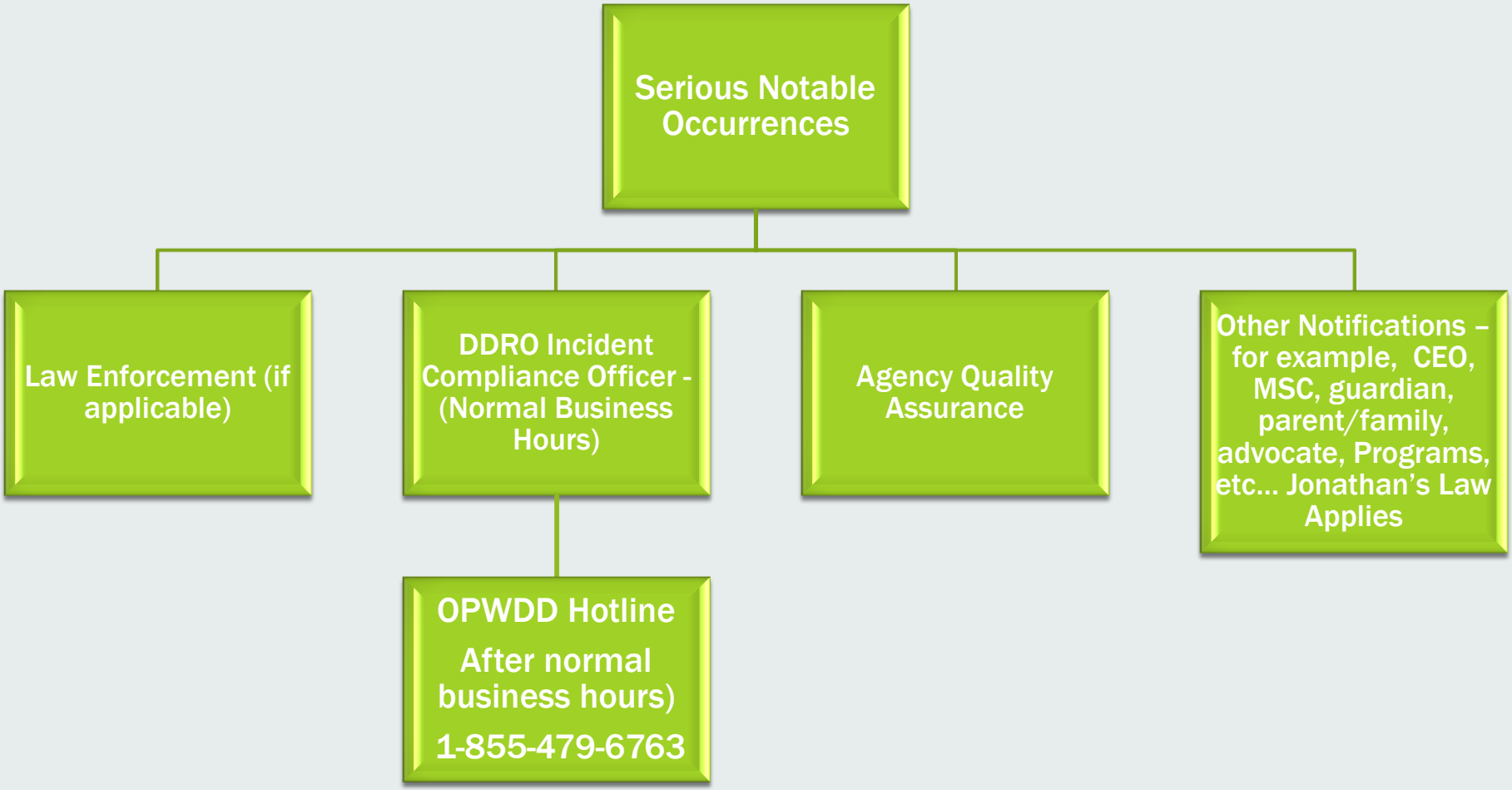
https://vpcr.justicecenter.ny.gov/wi

NOTIFICATIONS FOR ABUSE AND NEGLECT AND SIGNIFICANT INCIDENTS

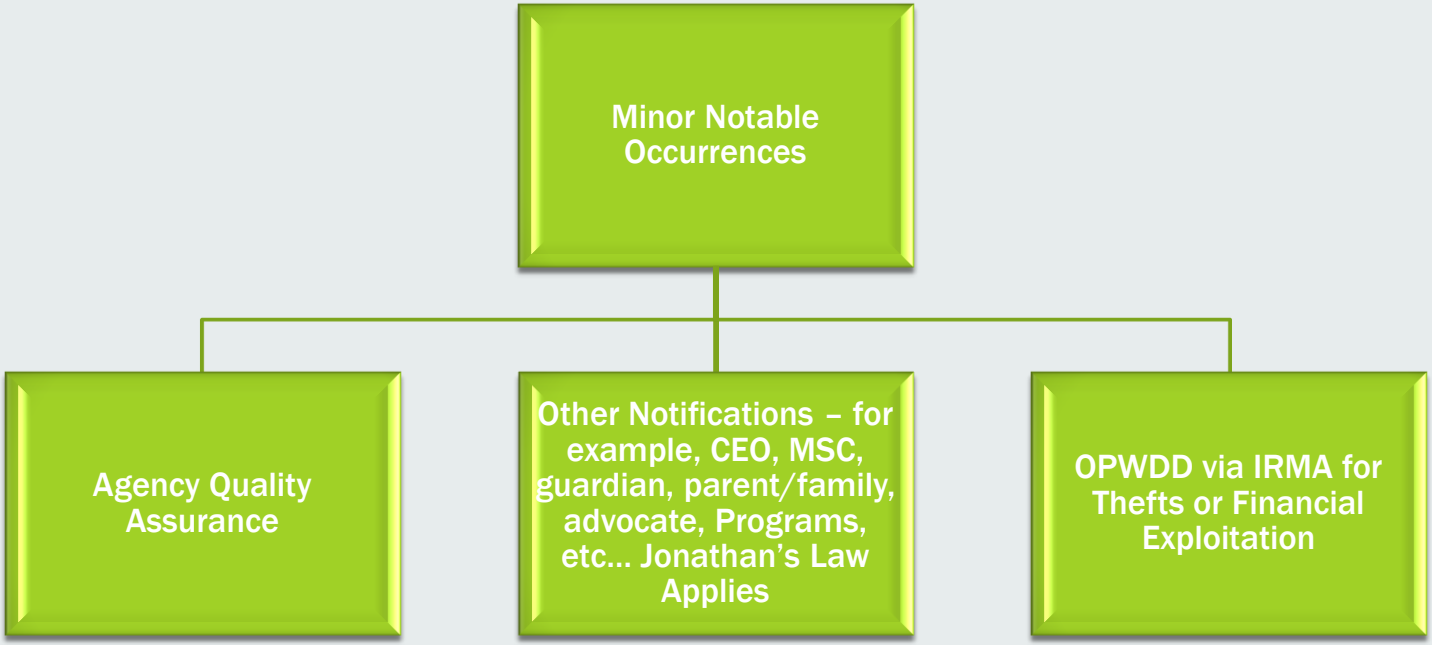


*Deaths must be reported within 24 hours to 1-855-373-2124.

NOTIFICATIONS FOR SERIOUS NOTABLE OCCURRENCES



NOTIFICATIONS FOR MINOR NOTABLE OCCURRENCES



SERVICE COORDINATION SUBSEQUENT INFORMATION

- Quality Assurance must supply Service Coordinator information needed to update the ISP.
- Info needed to monitor protective, corrective and other actions taken.
- Info regarding the findings of abuse/neglect, (e.g. substantiated, unsubstantiated, concurrent finding)
- Recommendations pertaining to the individuals care, protection and treatment
- Excludes information that identifies anyone except the individual service by the SC
- Information is provided within 10 days of completion of the investigation.
- If SRC results in additional recommendations regarding the individuals care, protection and/or treatment additional info provided to the SC must be done within 3 weeks of the committee review.

JONATHON'S LAW

- All types of Part 624 Incidents and Allegations of Abuse/Neglect require Jonathan's Law Notification.

REPORTING OF CHILD ABUSE

- Any agency employee who witnesses or becomes aware of a situation involving suspected child abuse or maltreatment is mandated to report it directly to the Statewide Central Register for Child Abuse and Maltreatment. Reports of suspected child abuse or maltreatment must be made for any child under the age of 18 regardless of whether or not the child is currently receiving services. Additional protections are identified for those individuals who receive residential services.
- Upon witnessing or becoming aware of suspected child abuse or maltreatment for any child under the age of 18 the witnessing/discovering staff must personally notify the Statewide Central Register for Child Abuse and Maltreatment of the situation by calling 1-800-635-1522.
- When notification is made the staff must include the name, title, and contact information for each staff person believed to have direct knowledge of the allegation.
- Once the report has been made, immediately notifies their supervisor and completes the NY State Office of Children and Family Services Report of Suspected Child Abuse or Maltreatment form.
- The Justice Center should be notified as well.

INVESTIGATIONS

INVESTIGATIONS

- Justice Center will determine who will conduct investigations
- Voluntary agencies must carry out investigations o abuse and neglect or significant events delegated to them by the Justice Center
- Reports have to be in the specified format (OPW 149)
- The Justice Center must receive all investigation reports and documentary evidence of all abuse/neglect investigations in certified settings upon completion.
- Employees will be notified by their supervisor if they have been identified as a subject at the onset of an investigation. Employees who become a subject during the investigation process will be notified as well by their supervisor. (Refer to Employee Notification FAQ)

INTERNAL INVESTIGATION

- Conducted at arms length and objectively
- All potential witnesses are interviewed
- All possible evidence is collected
- A written final report is generated, including:
  - Conclusions drawn from the majority of evidence
  - Recommendations to prevent recurrence

INVESTIGATIONS FINDINGS

- Are required for all allegations of abuse or neglect
- Will either be substantiated or unsubstantiated based on the preponderance of evidence gathered during the investigation.
- A concurrent finding can also be made to the finding if a system problem contributed to the occurrence.
- The agency's has an Incident Review Committee but their role is limited for any investigation conducted by OPWDD or the JC.
- The Justice Center forwards all substantiated investigations of abuse/neglect to the Office of General Council to determine the category of substantiated abuse.
  - Category 1, 2, 3, 4

WHAT ARE CATEGORIES PERTAINING TO SUBSTANTIATIONS OF ABUSE AND NEGLECT?

1	Substantiated serious physical abuse, sexual abuse or other serious conduct. Employee is placed permanently on the SEL and is terminated immediately, if not already.
2	Conduct that seriously endangers health, safety or welfare of a service recipient and requires progressive discipline and a plan by the provider agency for training and prevention of reoccurrences. A category 2 may become a category 1 if another category 2 incident occurs within 3 year. A category 2 may be sealed after five years if no other incidents occur.
3	Abuse or neglect not to the level of category 1 or 2 and requires a prevention plan by the provider agency and remediation. A category 3 will be sealed after five years in no other incidents occur.
4	Service recipient was exposed to harm, or risk of harm, but staff culpability may have been mitigated by systemic problems or perpetrator cannot be identified. Provider agency must develop a plan for prevention and remediation.

STAFF EXCLUSION

STAFF EXCLUSION LIST

- The Justice Center will be maintaining a Vulnerable Persons Central Registry (VPCR) that will include a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse and are deemed ineligible to work in a position involving regular and substantial contact with a service recipient. (Certified Programs/settings)
- Persons on the permanent Staff Exclusion List can never work in any of the 6 NYS Oversight Agencies (OPWDD, OMH, OASAS, DOH, OCFS, SED)
- The list must be checked before determining whether to hire or otherwise allow "any person" to have regular and substantial contact with the service recipient.
- Any person can include an employee, administrator, consultant, intern, volunteer or contractor.

WHAT IS MHL 16.34?

- Effective June 30, 2013, Section 16.34 of the New York State Mental Hygiene Law (MHL) requires a background check for prospective employees and volunteers in the OPWDD system, which is referred to as a MHL 16.34 check.
- The MHL 16.34 check will give agencies that are considering an applicant for employment or volunteer activity information about substantiated reports of abuse and neglect that occurred prior to June 30, 2013 involving the applicant as a target.
- The information about prior substantiated allegations of abuse or neglect by OPWDD through a MHL 16.34 check process will enable potential employers to screen out applicants who are not appropriate for employment or volunteer work that involves contact with individuals receiving services in the OPWDD system.
- Section 16.34 of the MHL limits information that can be disclosed about past substantiated allegations of abuse or neglect in several ways.
  - The substantiated allegation must be from a program certified or operated by OPWDD. (Substantiated allegations from voluntary operated non-certified programs may not be disclosed.)
  - The substantiated allegation must be for physical abuse, sexual abuse, psychological abuse or "serious neglect." "Serious neglect" means intentional acts or omissions that endanger the life or health of a person receiving services.
  - The subject of the substantiated allegation must have been an employee or volunteer only (e.g. not a contractor, consultant, family care provider, family member, etc.).
  - If the information about the substantiated allegation can be disclosed, the past employer prepares a "summary report and sends the summary report to OPWDD Incident Management Unit with a completed Form OPWDD 153 Agency Response to OPWDD Request to Search Abuse/Neglect History Records.