REPORTABLE INCIDENTS

§ 6000.921. Categories of Incidents.

(a) The following are the categories of incidents to be responded to by staff who are knowledgeable about incident management processes and protecting individuals. After the immediate health and safety assurances have been met, these incidents are to be reported in HCSIS. The categories are divided into those that must be reported within 24 hours of discovery or recognition and those that are to be reported within 72 hours.

(b) For the incidents that require reporting within 24 hours, the first section of the incident report must be completed in HCSIS within 24 hours. The first section includes a minimum data set (individual and provider demographics, action taken to protect the individual and description of the incident and the category of incident). The final section of the incident report includes additional information about the incident, any required investigation and corrective actions. The final section is to be completed within 30 days of recognition or discovery of the incident.

(c) The second set of incidents requires reporting within 72 hours of recognition or discovery. These incidents are reported using abbreviated data entry screens in HCSIS.

(d) When multiple individuals associated with a provider/entity are involved in certain primary categories or secondary categories, or both, of incidents, the incident can be reported using a site report. Only those events designated in the list of reportable incidents as a site report may be filed in this manner. An individual who is part of a group involved in a site report and is injured must have a separate individual report completed using the proper classification.

(e) Providers, supports coordination entities, counties and OMR must be vigilant to report any incident where there is a suspected crime to law enforcement. When an individual is allegedly abused, neglected or the victim of a crime, the individual is to be offered the support of a victim’s assistance program. See Appendix G, (relating to victim’s assistance programs).

§ 6000.922. Incidents to be reported within 24 hours.

(a) The following are categories of incidents to be reported within 24 hours after the occurrence of the incident:

1. Abuse. The allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Abuse is reported on from the victim’s perspective, not on the person committing the abuse.

   (i) Physical abuse. An intentional physical act by staff or other person which causes or may cause physical injury to an individual, such as striking or kicking, applying noxious or potentially harmful substances or conditions to an individual.
(ii) **Psychological abuse.** An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(iii) **Sexual abuse.** An act or attempted acts such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Any sexual contact between a staff person and an individual is abuse.

(iv) **Verbal abuse.** A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(v) **Improper or unauthorized use of restraint.** A restraint not approved in the individual support plan or one that is not a part of an agency’s emergency restraint procedure is considered unauthorized. A restraint that is intentionally applied incorrectly is considered an improper use of restraint.

(2) **Death.** All deaths are reportable.

(3) **Disease reportable to the Department of Health** – An occurrence of a disease on *The Pennsylvania Department of Health List of Reportable Diseases*. The current list can be found at the Department of Health’s website, [www.health.state.pa.us](http://www.health.state.pa.us). An incident report is required only when the reportable disease is initially diagnosed.

(4) **Emergency closure.** An unplanned situation that results in the closure of a home or program facility for 1 or more days. This category does not apply to individuals who reside in their own home or the home of a family member. This may be reported as a site report.

(5) **Emergency room visit.** The use of a hospital emergency room. This includes situations that are clearly “emergencies” as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of the physician's office, is not reportable.

(6) **Fire.** A situation that requires the active involvement of fire personnel, that is extinguishing a fire, clearing smoke from the premises, responding to a false alarm, and the alike. Situations which require the evacuation of a facility in response to suspected or actual gas leaks or carbon monoxide alarms, or both, are reportable. Situations in which staff extinguish small fires without the involvement of fire personnel are reportable. This may be reported as a site report.

(7) **Hospitalization.** An inpatient admission to an acute care facility for purposes of treatment. Scheduled treatment of medical conditions on an outpatient basis is not reportable.
Individual-to-individual abuse. An interaction between one individual receiving services and another individual receiving services resulting in an allegation or actual occurrence of the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation. Individual-to-individual abuse is reported on from the victim's perspective, not on the person committing the abuse.

(i) Physical abuse. An intentional physical act that causes or may cause physical injury to an individual, such as striking or kicking, or applying noxious or potentially harmful substances or conditions to an individual.

(ii) Psychological abuse. An act, other than verbal, which may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

(iii) Sexual abuse. An act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and inappropriate or unwanted touching of an individual by another. Nonconsensual sex between individuals receiving services is abuse.

(iv) Verbal abuse. A verbalization that inflicts or may inflict emotional harm, invoke fear or humiliate, intimidate, degrade or demean an individual.

Injury requiring treatment beyond first aid. Any injury that requires the provision of medical treatment beyond that traditionally considered first aid. First aid includes assessing a condition, cleaning an injury, applying topical medications, applying a Band-Aid, and the like. Treatment beyond first aid includes lifesaving interventions such as CPR or use of the Heimlich maneuver, wound closure by a medical professional, casting or otherwise immobilizing a limb. Evaluation/assessment of an injury by emergency personnel in response to a “911” call is reportable even if the individual is not transported to an emergency room.

Law enforcement activity. The involvement of law enforcement personnel is reportable in the following situations:

(i) An individual is charged with a crime or is the subject of a police investigation that may lead to criminal charges.

(ii) An individual is the victim of a crime, including crimes against the person or their property.

(iii) A crime such as vandalism or break-in that occurs at a provider site. This may be reported as a site report.

(iv) An on-duty employee or an employee who is volunteering during off duty time, who is charged with an offense, a crime or is the subject of an investigation while on duty or volunteering. This is reported as a site report.
(v) A volunteer who is charged with an offense, a crime or is the subject of an investigation resulting from actions or behaviors that occurred while volunteering. This is reported as a site report.

(vi) A crisis intervention involving police/law enforcement personnel.

(vii) A citation given to an agency staff person for a moving violation while operating an agency vehicle, or while transporting individuals in a private vehicle, is reported as a site report.

(11) **Missing person.** A person is considered missing when they are out of contact with staff for more than 24 hours without prior arrangement or if they are in immediate jeopardy when missing for any period of time. A person may be considered in “immediate jeopardy” based on the person’s personal history and may be considered “missing” before 24 hours elapse. Additionally, it is considered a reportable incident whenever the police are contacted about an individual or the police independently find and return the individual, or both, regardless of the amount of time the person was missing.

(12) **Misuse of funds.** An intentional act or course of conduct, which results in the loss or misuse of an individual’s money or personal property. Requiring an individual to pay for an item or service that is normally provided as part of the individual support plan is considered financial exploitation and is reportable as a misuse of funds. Requiring an individual to pay for items that are intended for use by several individuals is also considered financial exploitation. Individuals may voluntarily make joint purchases with other individuals of items that benefit the household.

(13) **Neglect.** The failure to obtain or provide the needed services and supports defined as necessary or otherwise required by law or regulation. This includes the failure to provide needed care such as shelter, food, clothing, personal hygiene, medical care, protection from health and safety hazards, attention and supervision, including leaving individuals unattended and other basic treatment and necessities needed for development of physical, intellectual and emotional capacity and well being. This includes acts that are intentional or unintentional regardless of the obvious occurrence of harm.

(14) **Psychiatric hospitalization.** An inpatient admission to a psychiatric facility, including crisis facilities and the psychiatric departments of acute care hospitals, for the purpose of evaluation or treatment, or both, whether voluntary or involuntary. This includes admissions for “23 hour” observation and those for the review or adjustment, or both, of medications prescribed for the treatment of psychiatric symptoms or for the control of challenging behaviors.

(15) **Rights violation.** An act which is intended to improperly restrict or deny
the human or civil rights of an individual including those rights which are specifically mandated under applicable regulations. Examples include the unauthorized removal of personal property, refusal of access to the telephone, privacy violations and breach of confidentiality. This does not include restrictions that are imposed by court order or consistent with a waiver of licensing regulations.

(16) **Suicide attempt.** The intentional and voluntary attempt to take one’s own life. A suicide attempt is limited to the actual occurrence of an act and does not include suicidal threats.
§ 6000.923. Incidents to be reported within 72 hours.

(a) The following are categories of incidents to be reported within 72 hours after the occurrence of the incident:

(1) **Medication error.** Any nonconforming practice with the “Rights of Medication Administration” as described in the OMR *Medication Administration Training Course*. This includes omission, wrong dose, wrong time, wrong person, wrong medication, wrong route, wrong position, wrong technique/method and wrong form. Over the counter medication is excluded. Treatment procedures (for example, skin creams, shampoo, eye drops, and the like) that do not contain a prescription medication are excluded. A medication error occurring during a home visit, when the family is responsible for the administration, is not reportable. An individual’s refusal to take medication is not reportable. See Appendix H. (relating to abbreviated incident report, medication error).

(2) **Restraints.** Any physical, chemical or mechanical intervention used to control acute, episodic behavior that restricts the movement or function of the individual or portion of the individual’s body, including those that are approved as part of an individual support plan or those used on an emergency basis. Improper or unauthorized use of restraint is considered abuse and is to be reported under the abuse category. See Appendix I (relating to abbreviated incident report, restraint).

(i) **Physical.** A physical or manual restraint is a physical hands-on technique that lasts thirty (30) seconds or more, used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual’s body such as a basket hold and prone or supine containment.

(ii) **Mechanical.** A mechanical restraint is a device used to control acute, episodic behavior that restricts the movement or function of an individual or portion of an individual’s body. Examples of mechanical restraints include anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, poseys, waist straps, head straps, restraining sheets and similar devices. A device used to provide support for functional body position or proper balance and a device used for medical treatment, such as a wheelchair belt or helmet for prevention of injury during seizure activity, are not considered mechanical restraints.

(iii) **Chemical.** A chemical restraint is a drug used to control acute, episodic behavior that restricts the movement or function of an individual. A drug ordered by a licensed practitioner as part of an ongoing treatment program or pretreatment prior to medical or dental examination or treatment is not a chemical restraint. Medications prescribed on a Pro Re Nata (PRN) basis for the treatment of episodically occurring and well-defined symptoms of an underlying disorder (such as an anxiety disorder, auditory hallucinations, and the
like.) and not simply for behavior control, are not considered chemical restraints. For further clarification see Mental Retardation Bulletin 00-02-09, issued July 11, 2002, titled *Pro Re Nata Medication Usage for Psychiatric Treatment – Clarification of Interpretation*. 
SEQUENCE OF REPORTING

§ 6000.931.. Multiple categories and sequences.

(a) Many real life occurrences may result in events that may be classified under multiple categories of incidents. In an attempt to assist the point person in identifying an appropriate order for reporting incidents that may be classified under multiple categories, the following sequence is suggested. This sequence may not be appropriate in all situations, but should be used as a guide in selecting the most appropriate category.

(1) 24-Hour Reporting Primary Incident Category

(i) Death.
(ii) Suicide attempt.
(iii) Hospitalization
(iv) Psychiatric hospitalization.
(v) Emergency room visit.
(vi) Abuse.
(vii) Individual to individual abuse.
(viii) Neglect.
(ix) Missing person.
(x) Injury requiring treatment beyond first aid.
(xi) Disease reportable to the Department of Health.
(xii) Fire
(xiii) Misuse of funds.
(xiv) Rights violation.
(xv) Law enforcement activity.
(xvi) Emergency closure.

(2) 72-Hour Reporting Primary Incident Category

(i) Medication error.
(ii) Restraint.

(b) If a death, hospitalization, psychiatric hospitalization, emergency room visit or injury requiring treatment beyond first aid is the result of a medication error or the use of a restraint, a report is to be initiated within 24 hours using the corresponding primary category. Data about the medication error or the restraint is also to be recorded within 72 hours in the abbreviated HCSIS data entry screens for medication error or restraint.
§ 6000.925. Categories of incidents to be investigated.

The following chart indicates those incidents to be investigated by the provider, the county and OMR. The investigation process does not preclude investigations by law enforcement or other agencies responsible to investigate.

<table>
<thead>
<tr>
<th>Primary Category</th>
<th>Secondary Category</th>
<th>Entity Responsible for Investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>All</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>Improper or unauthorized use of restraint</td>
<td>Provider and County</td>
</tr>
<tr>
<td>Neglect</td>
<td>All</td>
<td>Provider</td>
</tr>
<tr>
<td>Rights Violation</td>
<td>All</td>
<td>Provider</td>
</tr>
<tr>
<td>Misuse of Funds</td>
<td>All</td>
<td>Provider</td>
</tr>
<tr>
<td>Death</td>
<td>When an individual is receiving services from a provider/entity. [see §6000.911 b (1)--(3)]</td>
<td>Provider and OMR or Department of Health (county participation as requested by OMR)</td>
</tr>
<tr>
<td>Hospitalization</td>
<td>Accidental Injury</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>Unexplained Injury</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>Staff to Individual Injury</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>Injury Resulting from Individual to Individual Abuse</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>Injury Resulting from Restraint</td>
<td>Provider and County</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>Unexplained Injury</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
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<td>Injury requiring treatment beyond first aid</td>
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<td>Provider</td>
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<td></td>
<td>Resulting from Individual to Individual Abuse</td>
<td>Provider</td>
</tr>
<tr>
<td></td>
<td>Injury Resulting from Restraint</td>
<td>Provider and County</td>
</tr>
<tr>
<td>Individual to Individual Abuse</td>
<td>Sexual Abuse</td>
<td>Provider</td>
</tr>
</tbody>
</table>
INCIDENT MANAGEMENT COMPONENTS

PROVIDERS/ENTITIES ARE TO:

- Promote the health, safety, rights and enhance the dignity of individuals receiving services.
- Develop provider-specific policy/procedures for incident management.
- Ensure that staff and others associated with the individual have proper orientation and training to respond to, report and prevent incidents.
- Provide ongoing training to individuals and families on the recognition of abuse and neglect.
- Ensure when incidents occur that affect a person’s health, safety or rights, that the people who are present:
  - Take prompt action to protect the person’s health, safety and rights. This includes separation of the target when the individual’s health and safety are jeopardized. This separation shall continue until an investigation is completed. In addition, the target shall not be permitted to work directly with any other service recipient during the investigation process. When the target is another individual receiving supports or services, and complete separation is not possible, the provider shall institute additional protections.
  - Notify the responsible person designated in provider policy.
- Assign trained individual(s) Point Person(s) to whom incidents are reported when they occur and who will make certain that all immediate steps to assure health and safety have been implemented and follow the incident through closure.
- Contact appropriate law enforcement agencies when there is suspicion that a crime has occurred.
- Comply with all applicable laws, regulations and policies.
- Conduct certified investigations.
- Analyze the quality of investigations.
- Respond to concerns from individuals/family about the reporting and investigation processes.
- Inform the family of the incident unless otherwise indicated in the individual’s plan.
- Notify the family of the findings of any investigation unless otherwise indicated in the individual’s plan.
- Maintain an investigation file within the agency.
- Create an incident management process which:
- Designates an individual with overall responsibility for incident management.
- Considers possible immediate and long-term effects to the individual resulting from an incident or multiple incidents.
- Uses trend analyses to identify systemic issues.
- Analyzes and shares information with relevant staff, including direct care staff.
- Periodically assesses the effectiveness of the incident management process.
- Monitors quality and responsiveness of all ancillary services (such as health, therapies, etc.) and acts to change vendors or subcontractors, or assists the individual to file available grievances or appeals procedures to secure appropriate services.

COUNTIES ARE TO:

- Promote the health, safety, rights and dignity of individuals receiving services.
- Develop county policies and procedures necessary to implement this bulletin.
- Have an administrative structure sufficient to meet mandates of this bulletin:
  - Designate an individual with overall responsibility for incident management.
  - Train staff in incident management procedures.
  - Assure that supports coordinators have proper orientation and training to respond to, document and prevent incidents.
  - Support providers with appropriate training and resources to meet the mandates of the bulletin.
- Provide ongoing training to individuals, families, guardians, and advocates regarding their rights, roles and responsibilities that are outlined in this bulletin.
- Provide training to individuals and families on the recognition of abuse and neglect.
- Have the Incident Management Processes in this bulletin referenced in county/provider contracts.
- Maintain an investigation file within the county.
- Create an incident management process which:
  - Assures accuracy of incident reports.
  - Reviews and closes all provider generated incidents.
  - Reviews and analyzes data.
  - Identifies and implements individual and systemic changes based on data analysis.
  - Analyzes and shares information with relevant staff.
  - Regularly reviews trend and occurrence data compiled by providers.
  - Assesses provider’s incident management and investigative processes.
  - Assures provider compliance with plans of correction resulting from incidents and investigations.
- Conduct certified investigations.
- Analyze the quality of investigations.
- Respond to concerns from individuals/family about the reporting and investigation processes.
In collaboration with the individual’s planning team, revise the individual’s plan as needed in response to issues identified through the incident management process.

Comply with all applicable laws, regulations and policies.

Coordinate with other agencies as necessary.

In those instances where the county is the initial reporter of the incident, the county will assume the responsibility of the point person.

THE OFFICE OF MENTAL RETARDATION IS TO:

- Promote the health, safety, rights and dignity of individuals receiving services.
- Create an incident management review process which:
  - Maintains the statewide data system.
  - Analyzes data for statewide trends and issues.
  - Identifies issues and initiates systemic changes and provides periodic feedback.
  - Evaluates county and provider reports and analysis of trends.
- Monitor implementation of this bulletin.
- Support providers and counties with appropriate training to meet the mandate of the bulletin.
- Certify investigators.
- Provide support and technical assistance to counties to implement the incident reporting system.
- Conduct certified investigations.
- Analyze the quality of investigations.
- Respond to concerns from individuals/families about the reporting and investigation processes.
- Review and revise this bulletin as needed.
- Ensure compliance with all applicable laws, regulations and policies.
- Coordinate with other agencies as necessary.
The incident management and reporting detailed in this subchapter are related to a variety of laws, regulations and policies. The applicable licensing regulations (and facilities licensed under those regulations) include:

Related Laws:

- The Mental Health and Mental Retardation Act of 1966 (50 P.S. §§ 4101-4704)
- Title XIX Social Security Act (42 U.S.C.A. §§ 1396-1396br)
- 18 Pa. C.S. § 2713 (relating to the neglect of care-dependent person)
- The Older Adults Protective Services Act (35 P.S. §§ 10225.101-10225.5102)
- Elder Care Payment Restitution Act (35 PS §§ 10226.101-10226.107)
- Early Intervention Services System Act (11 P.S. §§ 875.101-875.503)
- The Whistleblower Law (43 P.S. §§ 1422-1428)

Title 55 of the Pennsylvania Code.

- Chapter 20 – Relating to Licensure or Approval of Facilities and Agencies
- Chapter 2380 – Relating to Adult Training Facilities
- Chapter 2390 – Relating to Vocational Facilities
- Chapter 3490 – Relating to Child Protective Services
- Chapter 3800 – Relating to Child Residential and Day Treatment Facilities
- Chapter 5310 – Relating to Community Residential Rehabilitation Services for the Mentally Ill
- Chapter 6400 – Relating to Community Homes for Individuals with Mental Retardation
- Chapter 6500 – Relating to Family Living Homes
- Chapter 6600 – Relating to Intermediate Care Facilities for the Mentally Retarded
Title 6 of the Pennsylvania Code. Aging.

- Chapter 11 – Relating to Older Adult Daily Living Centers

Related Policy Guidelines:

- Mental Retardation Bulletin 00–98–08 - Procedures for Substitute Health Care Decision Making (effective November 30, 1998)
- Mental Retardation Bulletin 00–94–32 - Assessments: Lifetime Medical History (effective December 6, 1994)
- Mental Retardation Bulletin 00–03–01 - Passage of Act 171 relating to the Older Adults Protective Services Act (OAPSA)

ADDITIONAL REPORTING:

In addition to the reporting methodologies described in this statement of policy, the following is provided as a guide to assist in identifying additional reporting. This does not fully define, nor is it intended to substitute for, the applicable statutes and regulations.

Reportable incidents involving individuals who reside in facilities licensed as ICF/MRs (both state and privately-operated), are to be reported to the appropriate Regional Field Office of the Pennsylvania Department of Health, Division of Intermediate Care Facilities.

Reportable incidents that occur in facilities licensed by OMR, involving individuals whose support needs are not funded through the Commonwealth or county mental retardation systems, are to be reported to whomever funds the individual’s support and to the Commonwealth/Regional Office of Mental Retardation. This includes individuals from other states, individuals who are funded by agencies not part of the mental retardation system and individuals whose support needs are privately funded.

NEGLECT OF CARE-DEPENDENT PERSON (TITLE 18 PA.C.S. § 2713)

The neglect of care-dependent person 18 Pa.C.S. § 2713 covers any adult who, due to physical or cognitive disability or impairment, requires assistance to meet his needs for food, shelter, clothing, personal care or health care. 18 Pa.C.S. § 2713 extends to certain listed facilities and to home health services provided to care-dependent persons in their residence. The statute criminalizes intentional, knowing or reckless conduct by a caregiver which results in bodily injury or serious bodily injury to a care-dependent person by the failure to provide treatment, care, goods or services necessary to preserve the health, safety or
welfare of a care-dependent person for whom the caregiver is responsible to provide care. A caregiver may also be prosecuted if he intentionally or knowingly uses a physical restraint, a chemical restraint or medication on a care-dependent person, or isolates that person, contrary to law or regulation, such that bodily or serious bodily injury results.

Anyone aware of possible violations of this may make a report to the appropriate law enforcement authorities. The reporting requirements of this bulletin are to be followed even if a report of a possible violation of this statute is made to law enforcement authorities. Copies of the statute were distributed via Mental Retardation Bulletin 00–95–25, issued December 26, 1995 and Mental Retardation Bulletin 00–97–06, issued August 29, 1997.

The Child Protective Services Law (23 Pa. C.S. §§ 6301-6385)

The Child Protective Services Law (CPSL) establishes procedures for the reporting and investigation of suspected child abuse. Certain types of suspected child abuse must be reported to law enforcement officials for investigation of criminal offenses. Children under the age of 18 are covered by the Act including those who receive supports and services from the mental retardation system. Providers covered within the scope of this bulletin are required to report suspected child abuse in accordance with the procedures established in the CPSL and the Protective services Regulations. The CPSL defines child abuse as any of the following when committed upon a child under 18 years of age by a parent, person responsible for a child's welfare, an individual residing in the same home as a child or a paramour of a child’s parent.

- Any recent act or failure to act that causes non-accidental serious physical injury.
- Any act or failure to act that causes non-accidental serious mental injury or sexual abuse or sexual exploitation.
- Any recent act or series of such acts or failures to act that creates an imminent risk of serious physical injury or sexual abuse or sexual exploitation.
- Serious physical neglect constituting prolonged or repeated lack of supervision or the failure to provide essentials of life including adequate medical care which endangers a child's life or development or impairs the child's functioning.

Reports of suspected abuse are received by the Department of Public Welfare's (DPW) ChildLine and Abuse Registry (800-932-0313), which is the central register for all investigated reports of abuse. Individuals who come into contact with children in the course of practicing their profession are required to report when they have reasonable cause to suspect on the basis of their medical, professional or other training or experience, that a child is an abused child. Every facility or agency is required by the CPSL to funnel reports to the director or a designee to be promptly reported to ChildLine. The reporting, investigation and
documentation requirements of this Mental Retardation Bulletin must also be followed when a report of suspected child abuse is made. It must be noted that the definition of abuse found in the CPSL differs greatly from the definition promulgated in this bulletin. Because of this difference it is possible that an allegation may be “unconfirmed” in terms of the CPSL but still substantiated with reference to these guidelines. Likewise, the scope of reports subject to investigation differs so it is important to be familiar with the requirements of the CPSL.

The Older Adults Protective Services Act (35 P.S. §§ 10225.101 - 10225.5102)

The Older Adults Protective Services Act (OAPSA) of 1987 was enacted to protect all Pennsylvanians age 60 and older. The OAPSA established a detailed system for reporting and investigating suspected abuse, neglect, exploitation, and abandonment for care-dependent individuals. Act 13 was signed into law in 1997 as an amendment to the OAPSA. Unlike the other provisions of OAPSA that applied only to adults age 60 and above, Act 13 applied to adults age 18 and above who were considered “care-dependent” individuals and to “care-dependent” individuals under age 18 if they resided in a facility serving individuals over 18. Employees or administrators of a covered entity reported suspected abuse incidents to the local Area Agency on Aging (AAA), where indicated, to the Pennsylvania Department of Aging and to local law enforcement pursuant to Chapter 7 of the OAPSA. These requirements existed in addition to the reporting procedures contained in this Bulletin. In 2002, the OAPSA was further amended by the Elder Care Payment Restitution Act.

The Elder Care Payment Restitution Act (35 P.S. §§ 10226.101 - 10226.107)

The Elder Care Payment Restitution Act eliminated the requirements of Act 13 for which suspected abuse of individuals with mental retardation under the age of 60 was reported to the Area Agency on Aging and in some cases, to the Department of Aging. This Act became effective February 9, 2003.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191)

HIPAA and the applicable regulations at 45 CFR Parts 160 and 164 (Privacy Rule) established a set of national standards for the protection of personal health information. The Privacy Rule addresses the use and disclosure of individuals’ health information or “protected health information” by organizations subject to the Privacy Rule or “covered entities”. The Privacy Rule establishes standards for individuals’ rights to understand and control how their personal health information is used. The U.S. Department of Health and Human Services, Office of Civil Rights is responsible to implement and enforce the Privacy Rule.
When individuals are abused, neglected, injured or victims of crimes, there are resources to assist them physically, emotionally, financially and legally. Organizations have been developed based on the need to support victims through the criminal justice system, recognizing that victim’s needs are oftentimes overlooked. Individuals with disabilities who fall victim to crimes, especially physical violence and sexual assaults, should be encouraged and assisted to access these resources. It is suggested that providers develop relationships with local entities and assist individuals in accessing such services when appropriate.

There are two main types of victim assistance programs: system and community-based organizations. System-based programs that generally operate out of a District Attorney’s office provide notification to victims/witnesses of court proceedings. Community based programs are designed to provide support and assistance to victims. Usually, the programs fall under the categories of:

- Rape Crisis/Sexual Assault programs providing services to victims and their family/supporters. Domestic Violence programs provide counseling and temporary housing to victims, as needed.
- Crime Victim Services provide supports and assistance to victims of crimes excluding sexual assaults and domestic violence.

There are domestic violence centers, rape crisis centers and victim assistance offices throughout the Commonwealth. In order to locate the most appropriate resource for individuals, you may contact the following statewide organizations. Additional information regarding local resources is available through these organizations:

- **PA Commission on Crime and Delinquency [PCCD]**
  
  [717] 787-2040

- **PA Coalition Against Rape [PCAR]**
  
  [800] 692-7445
  
  [717] 728-9740

- **PA Coalition Against Domestic Violence [PCADV]**
  
  [800] 932-4632

- **Office of Victim Advocate [crime victim compensation]**
  
  [717] 783-7501

- **Pennsylvania Protection and Advocacy [PP&A]**
  
  [800] 692-7443
OMR Incident Management Bulletin, Revised
February 28, 2004

Appendix H

ABBREVIATED INCIDENT REPORT
Medication Error

The data entry screen is to include the following information:

- DEMOGRAPHICS (pre-populated from HCSIS demographics)
  - Name of the individual for whom the Medication Error is being reported.
  - Individual’s Base Service Unit (BSU) number.¹

- CATEGORIZATION
  - Secondary category of Medication Error.
  - Date and time when the incident was recognized/discovered.

- MEDICATION ERROR INCIDENT INFORMATION
  - Staff position of the person giving medication.
  - Name of medication(s).
  - Indication if the error occurred over multiple consecutive administrations.
  - The reason(s) why the Medication Error occurred.
  - The response(s) to the Medication Error.
  - The agency system response to prevent this type of error from occurring in the future.
  - Any additional comments.
  - Indication if another Incident Report was filed as a result of the Medication Error.
  - If another Incident Report was filed, the Incident ID number.

In addition to the required information, providers may choose to include optional information to further analyze their medication errors.

¹ If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.
- The name or unique identifier of person making the Medication Error.
- Indication if the person making the Medication Error was working longer than their regular work hours at the time of the Medication Error.
- The length of time the staff person who made the Medication Error has been giving medications.
- The number of medications supposed to be given to this person at the same time as the Medication Error was made including the medication when the Medication Error was made.
- The number of medications this person receives on a daily basis.
- The number of people that the staff person who made the Medication Error has to give medications to around the same time as the Medication Error occurred.
The data entry screen is to include the following information:

- **DEMOGRAPHICS** (pre-populated from HCSIS demographics)
  - Name of the individual for whom the Restraint was used.
  - Individual’s Base Service Unit (BSU) number.1

- **CATEGORIZATION**
  - Secondary category of Restraint.
  - Date of the Restraint.
  - Time in Restraint.
  - Time out of Restraint.

- **RESTRAINT INCIDENT INFORMATION**
  - Restraint agent.
  - Antecedent to the Restraint.
  - Reason for the Restraint.
  - Indication if the Restraint was used on a planned or emergency basis.
  - Authorizing Staff.
  - Indication if Prone (face down) Restraint was used.
  - Indication if another Incident Report was filed as a result of the Restraint.
  - If another Incident Report was filed the Incident ID number.

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1 If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.
INCIDENT MANAGEMENT CONTINGENCY PLAN

In the event that a provider or county or entity is unable to report a 24-hour incident through the Home and Community Services Information System (HCSIS), faxed contingency reporting is to be utilized.

Incidents that are reported via fax are to be recorded on a copy of the attached Incident Management Contingency Form. This reporting method will satisfy regulatory requirements to report an incident. In the event of a serious incident (such as abuse with injury, suspicious death), a provider should also call their OMR Regional Office and County MH/MR Program to alert OMR and the county of the incident.

Once complete, the Incident Management Contingency Form is to be faxed to the appropriate OMR Regional Office and to the County MH/MR Program. The form should have a fax cover sheet that identifies the fax as a reportable incident and states the reason that the report needed to be faxed. Faxing the Incident Management Contingency Form is a short-term solution for meeting regulatory requirement for reporting incidents; however, once access to HCSIS can be established, the incident must be entered into HCSIS.

CONTACT INFORMATION:

OMR Regional Office Fax Numbers:

- Northeast Region (570) 963-3177
- Southeast Region (215) 560-3043
- Central Region (717) 772-6483
- Western Region (412) 565-5479

OMR Regional Office Phone Numbers:

- Northeast Region (570) 963-4391
- Southeast Region (215) 560-2242
- Central Region (717) 772-6507
- Western Region (412) 565-5144
INCIDENT MANAGEMENT
CONTINGENCY FORM

FOR USE ONLY WHEN HCSIS IS NOT AVAILABLE

The Incident Report must be entered into HCSIS when access to HCSIS can be established.

| NAME OF INDIVIDUAL (LAST, FIRST, M.I.) | PROVIDER NAME: |
| ADDRESS: | ADDRESS: |
| CITY | STATE | ZIP CODE | CITY | STATE | ZIP CODE |
| PHONE: | COUNTY OF REGISTRATION: | PHONE: |
| BASE SERVICE UNIT NUMBER: | |

DATE OF BIRTH: MM DD YYYY
SEX: 
□ MALE □ FEMALE

DATE THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED: MM DD YYYY

CLASSIFICATION OF INCIDENT:

TIME THE INCIDENT OCCURRED OR WAS RECOGNIZED/DISCOVERED:
AM/PM

DATE AND TIME OF DEATH (IF APPLICABLE):

PROVIDER LICENSE NUMBER (IF APPLICABLE):

DESCRIBE THE TYPE OF INCIDENT AND THE ACTION(S) TAKEN TO ADDRESS THE INDIVIDUAL’S HEALTH AND SAFETY AND THE RESPONSE TO THE INCIDENT, WHAT HAPPENED, IF A MEDICAL REFERRAL WAS NECESSARY (PLEASE LIST) AND ANY CIRCUMSTANCES WHICH MAY HAVE PRECIPITATED THE INCIDENT: (ATTACH ADDITIONAL SHEETS IF NECESSARY)

NAME OF RELATIVE OR GUARDIAN: RELATIONSHIP: NOTIFIED (YES/NO)

NAME OF POINT PERSON: TITLE: PHONE:
STANDARDIZED INCIDENT REPORT

FIRST SECTION (completed within 24 hours)

The First Section is to include the following information:

- DEMOGRAPHICS (pre-populated from HCSIS demographics)
  - Name of the individual involved/affected by the incident.
  - Individual’s Base Service Unit (BSU) number.\(^1\)
  - County of Registration.
  - Gender.
  - Individual’s date of birth.
  - MR Diagnosis.
  - Home address of the individual.
  - Living Arrangement of the individual.
  - Name and address of the reporting entity.
  - Location where the incident occurred.
  - Name of the point person.

- CATEGORIZATION
  - Date and time when the incident was recognized/discovered.
  - Primary and secondary category of the incident.
  - Determination if an investigation is required or desired.
  - Name of the Certified Investigator assigned, if the incident requires investigation.

- HEALTH AND SAFETY ASSURANCE
  - Description of the immediate and subsequent steps taken by the point person or other representatives of the provider to ensure the individual’s health, safety and response to the incident, including date, time and by whom those steps were taken.

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1. If the individual is not registered with a County MH/MR Program, the report is to list the county or state where the person is/was a resident.
INCIDENT DESCRIPTION

- Narrative description of the incident completed by staff or other person(s) who were present when the incident occurred or who discovered that an incident had occurred.¹

FINAL SECTION (completed within 30 days)

The reporting entity will complete the Final Section of the incident report within 30 days from the date of the incident or of the date the provider learns of the incident (unless an extension has been made). The Final Section will retain all of the preceding information from the First Section and will add:

- Name of the initial reporter.
- Name of the individual’s supports coordinator (pre-populated).
- Whether CPR was administered.
- Whether the Heimlich was administered.
- If 911 was called, the time, date and person who called.
- If the incident involves an illness or injury, the name of the practitioner/facility by whom the individual was treated initially, the date and time of the initial contact with a healthcare/medical practitioner, the nature/content of the initial treatment/evaluation, and the nature of, date of, time of, and practitioner involved in any subsequent treatments, evaluations.
- In the event of a death, indication if the individual was in hospice care, had a diagnosis of terminal illness, if a “Do Not Resuscitate” order was in effect, if the coroner was contacted, if an autopsy has been or will be performed.
- Identification of all persons to whom the incident notification has been (or will be) submitted (i.e., family, law enforcement agency), the date the notification has been made, and the person who has/will notify the necessary parties.
- Update of incident description, as needed.
- Specific description of any injury received by the individual.
- Present status of the individual in reference to the incident.
- Identification of other persons who may have witnessed or been directly involved in the incident.
- Specific signs and symptoms of any illness (acute or chronic) which may be contributory to the incident.
- Any relevant background information on the individual, including medical history and diagnoses.
- Date on which the investigation began, if required.
- Summary of the investigator’s findings and conclusions, if required.

¹ Providers may summarize the narrative description, but the written statements of the person(s) directly involved are to be available for review, if needed.
If the incident involves an allegation of abuse or neglect, the conclusion reached on the basis of the investigation (i.e., the allegation is confirmed, not confirmed, inconclusive) and the status of the target.

- Description of the steps taken by the provider in response to the conclusions reached as a result of the investigation.
- If the incident involves an injury of unknown origin, confirmation of the cause (if one has been identified) and steps taken to prevent recurrence.
- Description of any changes in the individual’s plan of support necessitated by or in response to the incident.
- Verification by the provider that all necessary corrective actions have been identified.
- If any corrective action cannot/has not been completed by the time the Final Section is submitted, the expected date of completion must be provided along with the identity of the person responsible for carrying the extended action through to completion.
- If the nature of the incident requires contact with local law enforcement, the name and department/office of the person(s) contacted, the date of the contact, the name of the person who initiated the contact, and a description of any steps taken by law enforcement officials.
- If the individual has been hospitalized, the date of admission, name of the hospital, the admitting diagnosis(es), indication if the admission was from the emergency room, what occurred during the hospitalization, change in voluntary/involuntary status, the date of discharge, the discharge diagnosis(es), an indication that the Hospital Discharge Instructions were provided, what changed after discharge, current status and any plans for subsequent medical follow-up.
- If the individual is deceased, the Final Section is to be supplemented by a hard copy of the following:¹
  - Lifetime medical history.
  - Copy of the Death Certificate.
  - Autopsy Report, if one has been completed.
  - Discharge Summary from the final hospitalization, if the individual died while hospitalized.
  - Results of the most recent physical examination.
  - Most recent Health and Medical assessments.
- Name of the family member notified of the results of the investigation, if required.
- The incident classification the provider believes is most appropriate.
- The date and time the provider believes is most appropriate.

After final submission by the provider, the county and OMR will perform a management review and close the incident.

¹ Documents, which are not immediately available, must be forwarded to the appropriate parties (county and/or OMR Regional Office) as they become available. If, after attempting to acquire the document, it is determined to be unobtainable, the expecting party will be notified.