Guide for Incident Management
OPWDD

Appendix A

revised 2/2020

Justice Center Reportable Incident classifications - Occur under the auspices of the agency. Report to the Justice Center for Certified Programs only. Notify OPWDD, UH Exec Dir, COO, Dept Dir, Dept Mgr., QA, Care Mgr., emergency contact, etc. Crimes against a service recipient must be reported to the police (physical, sexual, and possible other incidents). Jonathans Law notification is required. Notification to MHLS is required for all allegations of abuse/neglect. If substantiated; do not bill for time incident occurred.

Abuse/Neglect - *Conduct by an employee*

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

Guide for Incident Management
OPWDD

revised 2/2020

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

Guide for Incident Management
OPWDD

revised 2/2020

Self-Abusive Behavior w/Injury	Self inflicted injury by a service recipient that requires medical care **beyond first aid.**
Injury with hospital admission	Injury requiring hospitalization. (Illness are not included.)
Theft/ Financial Exploitation	Suspected theft of a service recipient's personal property or financial exploitation involving a value of more than $100.00; theft involving a service recipient's credit, debit, or public benefit card (regardless of the amount involved). The police must be called.
Other Significant Incident	Occurs under the auspices of the agency, but that does not involve conduct on the part of an employee and does not meet the definition of any other incident described in 624. However, because of its severity or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in harm to the health, safety, or welfare of a person receiving services.

Guide for Incident Management
OPWDD

revised 2/2020

Serious Notable Occurrences - Sensitive Situations: do not report to the Justice Center; reportable to OPWDD only. Death: reported to the Justice Center death reporting line. Notify OPWDD, UH Exec Dir, COO, Dept Dir, Dept Mgr., QA, Care Mgr., emergency contact, etc.

Death	The death of any person receiving services, regardless of the cause of death. All deaths of individuals who live in residential facilities operated or certified by OPWDD and other deaths that occur under the auspices of the agency. Only 1 person from the agency calls the death reporting line (person with most information). 1-855-373-2124 - Death reporting line. **ONLY** if the death appears to be the result of abuse or neglect, the JC VPCR needs to also be called.
Sensitive Situation	Situation of delicate nature to the agency. Also includes possible criminal acts committed by an individual receiving services.

Minor Notable Occurrences - Do not report to the Justice Center; reportable to OPWDD only through an IRMA entry (phone notification to OPWDD is not required but is appreciated). Notify OPWDD, UH Exec Dir, COO, Dept Dir, Dept Mgr., QA, Care Mgr., emergency contact, etc.

Injury	Injury that requires more than first aid. Illness is not reportable.
Theft or Financial Exploitation	Suspected theft of a service recipient's supervised personal property or financial exploitation involving values of more than $15 and less than or equal to $100. If unsupervised spending is missing, not reportable to OPWDD or JC; unless the individual has alleged a theft - then reportable to OPWDD. The police must be called.

Guide for Incident Management
OPWDD

revised 2/2020

Part 625 Events/Situations: do not occur under the auspices of an agency. Do not report to the Justice Center. Phone notification to OPWDD for Physical Abuse only is required. All other classifications, phone notification to OPWDD is not required but appreciated. Must be entered in IRMA within 48 hours. For Supportive Apartments, if staff *were not* providing oversight at the time of the event/situation, it is Part 625. If staff *were* providing oversight, it is Part 624. Notify OPWDD, UH Exec Dir, COO, Dept Dir, Dept Mgr., QA, Care Mgr., emergency contact, etc.	
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.
Passive Neglect	Non-willful failure of a caregiver to fulfill functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, denial of food, health related services **because of inadequate caregiver knowledge, infirmity or disputing the value of prescribed services.**
Active Neglect	Willful failure by a caregiver to fulfill the functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health related services.
Self Neglect	Service Recipient's inability, due to physical and/or mental impairments, to perform tasks essential to care for oneself, including but not limited to, providing essential food, clothing, shelter, medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety or managing financial affairs.
Financial Exploitation	Use of a service recipient's funds, property, or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement, conspiracy, forgery, falsifying records, coerced property transfers, or denial of access to assets.
Emotional Abuse	Willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other abusive conduct, including but not limited to, frightening or isolating a service recipient.
Death	Expected or unexpected end of life, regardless of cause.
Other	Possible Criminal Acts, missing persons, sensitive situations of significant concern.

Agency Reportable Minor Incident: A noteworthy event or situation that does not endanger the general wellbeing of the service recipient and does not meet the definition of a reportable incident; cause known or of unknown origin. Agency reportable only in FootHold.	
Fall	Require only first aid. Nursing must be notified of all falls. For a fall with head injury or trauma, follow the head injury protocol and implement neuro checks. For unwitnessed falls nuero checks need to be implemented.
Minor Injury	Bruise, scratch, abrasion, burn or sunburn; approximate size: the palm of a hand or larger. Human bite causing skin break. Insect bite showing signs of an allergic reaction.

Appendix B

OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTING

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

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

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

OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTING

	Incident Type – Subtype	Definition	Required Reporting
SIGNIFICANT INCIDENTS	**SIGNIFICANT INCIDENT:** The following incidents are **Significant Incidents**, reportable to the Justice Center and OMH, when they **occur on program premises** or when the patient was **under the actual or intended supervision** of a custodian:		**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at: https://vpcr.justicecenter.ny.gov/WIRW/#/ 2. **Report to OMH:** After the report is made to the JC, the information will be transferred to the **Justice Center Import queue in NIMRS.** The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and "close" report in NIMRS within 45 days
	Assault**	A violent or forceful physical attack by a person other than a custodian, in which a patient is either the victim or aggressor, and which results in serious injury or harm.	
	Crime	An event which is or appears to be a crime under New York State or Federal law which 1) involves a patient as a victim, or 2) which affects or has the potential to affect the health or safety of one or more patients of the program or 3) has the potential to have a significant adverse impact on the property or operation of the program.	
	Falls by Patients**	Events where patients trip, slip or otherwise fall in an inpatient or residential setting, resulting in serious injury or harm	
	Fights**	A physical altercation between two or more patients, in which there is no clear aggressor and no clear victim, resulting in serious injury or harm	
	Financial Exploitation	The use, appropriation, or misappropriation by a custodian of a patient's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the patient of those resources.	
	Fire Setting	Action by a patient, either deliberate or accidental, that results in fire on program premises.	
	Injury of Unknown Origin*	Any suspicious injury to a patient for which a cause cannot be immediately determined.	
	Medication Error**	An error in prescribing, dispensing, or administering a drug which results in serious injury or harm	
	Missing Patient (Inpatient/Residential)	A patient of an inpatient or residential program who has not been accounted for when expected to be present (in accordance with facility or program practice or policies) and who has not been found on the facility grounds or other expected location, or who is known to have left the facility grounds without the permission of an employee, when such permission is otherwise required and who is considered dangerous to others or unable to care for him/herself; or a patient of an outpatient program who is under the age of 18, and whose whereabouts is not accounted for when expected to be present or under the supervision of an employee.	
	Mistreatment: **– Unauthorized Restraint or Seclusion**	Unauthorized use of restraint or seclusion that is inappropriate because it was implemented without a valid physician's order or in a manner that was otherwise not compliant with applicable state or federal regulations, but which does not rise to the level of abuse (i.e. physical abuse or Deliberate Inappropriate Use of Restraint.	
	– Inappropriate use of Time Out	Use of time out to remove a patient from regular programming and isolate him/her in an area for the convenience of a custodian or as a substitute for programming	
	– Intentional Improper Administration of medication	Intentional administration to a patient of a prescription drug or over-the-counter medication which is not in substantial compliance with a prescription.	
	Self-Abuse**	Self-inflicted injury not intended to result in death that results in serious injury or harm.	

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

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

OMH NIMRS DEFINITIONS FOR INCIDENT TYPES AND REPORTING

Incident Type – Subtype		Definition	Required Reporting
SIGNIFICANT	Severe Adverse Drug Reaction**	Unintended, unexpected, or excessive response to a medication given at normal doses, which results in transfer to ER or serious injury or harm.	**Report to JC & OMH** 1. **Report to the JC:** Call 1-855-373-2122 or submit the web form which can be accessed at https://vpcr.justicecenter.ny.gov/WIRW/#/ 2. **Report to OMH:** After the report is made to the JC, the information will be transferred to the **Justice Center Import queue in NIMRS.** The report must be imported as a NIMRS incident and then "emailed" to OMH. 3. Investigate, document findings and "close" report in NIMRS within 45 days.
	Sexual Assault	A sexual attack including but not limited to those that result in vaginal, anal, or oral penetration, i.e., rape or attempted rape and sodomy or attempted sodomy; and/or any sexual contact between a person who is 18 years old or more and a person who is less than 15 years old, or between a person who is 21 years of age or older and a person who is less than 17 years old, or which involves a patient who is deemed incapable of consent	
	Sexual Contact Between Children	Vaginal, anal, or oral penetration by patients under age 18 that occurs in a setting where the patient receives around-the-clock care or on the premises of an outpatient program.	
	Suicide Attempt	An act committed by a patient of a mental health provider in an effort to cause his or her own death.	
	Verbal Aggression by Patients**	A sustained, repetitive action or pattern by a patient or patients of ridiculing, bullying, demeaning, making derogatory remarks, verbally harassing, or threatening to inflict physical or emotional harm on another patient or patients, which causes serious injury or harm.	
	Wrongful Conduct	Actions or inactions on the part of the custodian that are contrary to sound judgment or training and which are related to the provision of services, the safeguarding of patient health, safety or welfare, or patient rights, but which do not meet the definition of abuse or neglect.	
	Other Incident**	An event, other than those identified above, which has or creates a risk of, an adverse effect on the life, health, or safety of a patient.	
OMH Incidents Report ONLY to OMH	**OMH INCIDENTS:** The following off-site incidents are reportable ONLY to OMH		**Report ONLY to OMH** 1. Log into NIMRS & select "New Incident" from the home screen. 2. A "pop-up" with info on the reporting process will be displayed. Click "x" to bypass. 3. Enter required information on each NIMRS screen and click "Email OMH". 4. Complete report and close within 45 days.
	Crime in the Community	An event which is, or appears to be, a crime under New York State or Federal law, and which is perceived to be a significant danger to the community or which involves a patient whose behavior poses an imminent concern to the community.	
	Missing Subject of AOT Court Order:	A client who is subject to an AOT court order who fails to keep a scheduled appointment and/or who cannot be located within a 24 hour period (Outpatient Only) Inpatient and residential programs should report missing AOT persons under "Missing Client".	
	Suicide Attempt, Off-site	An act committed by a patient of a mental health provider in an effort to cause his or her own death that occurs off program premises or when the patient was not under the actual or intended supervision of a custodian.	

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

CALL (518) 474-3619 IF YOU HAVE ANY QUESTIONS ABOUT REPORTING AN INCIDENT

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

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

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

Appendix C

10/28/14, 10/6/16, 1.2018, 6.2018

Reportable Incidents - Occur under the auspices of the agency. Reported to the Justice Center for Certified Programs. All reportable incidents are reported to OASAS, Exec. Dir, and MHLS.

Abuse/Neglect

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

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

10/28/14, 10/6/16, 1.2018, 6.2018

Significant Incidents - Reportable to the JC, OASAS and Exec Dir. Because of the severity of the situation or the sensitivity of the situation may result in, or has the reasonably foreseeable potential to result in, harm to the health, safety, or welfare of a person receiving services.	
Conduct Between Individuals Receiving Services	Conduct between persons receiving services, which if committed by a custodian, would constitute abuse.
Unauthorized Seclusion	Placement of an individual in a room or area from which he or she cannot, or perceives that he or she cannot, leave at will.
Unauthorized Use of Time-Out	A person is removed from regular programming and isolated in a room or area for the convenience of a custodian, or as a substitute for programming; but shall not include the use of a time-out as an emergency intervention to protect the health or safety of the individual or other persons.
Medication Error with Adverse Effect	The administration of a prescribed or over-the-counter medication, which is inconsistent with a prescription or order, which has an adverse effect on an individual receiving services. Adverse effect: the unanticipated and undesirable side effect from the administration of a particular medication which unfavorable affects the well being of a person receiving services. Any medication error involving a controlled substance must be reported to the JC and OASAS.
Inappropriate Use of Restraints	The use of a restraint when the technique that is used, the amount of force used, or the situation in which the restraint is used is inconsistent with an individual's plan of service and/or generally accepted treatment practices and/or applicable laws and regulations.
Crime	An event that is, or appears to be, a crime under NYS or Federal law involving custodians, clients, including children of service recipients in a residential program, or others as victims or perpetrators.
Body Cavity Search	Must be with client consent.
Violation of Confidentiality	Pursuant to 42 CFR part 2 or the HIPAA.
Death	Any death of a current client (or within 30 days of the client's discharge).

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

Missing Client	If the service recipient has not been accounted for when and where such client is expected to be present and, after 24 hours, whose location has not been determined by means of immediate and appropriate diligent efforts. *A missing client could be the result of NEGLECT, if the service recipient required 24/7 staff supervision and the client's whereabouts is unknown because of staff failure to supervise. A missing client is NOT a service recipient who leaves against medical advice or is administratively discharged or who chooses to leave treatment and makes his/her choice known. Providers should always take responsible action, pursuant to program policy and considering confidentiality, to reach out to a service recipient's emergency contact to verify the person's safety.*
Suicide Attempt	Whether or not preceded by statement of intent; statement of intent alone is not a suicde attempt; statements of intent should be recorded in a patient's clinical record.
Children residing in programs with parents in treatment	Any incidents involving children in a program are reportable. Incidents involving children may require multiple notifications (SCR, police, court/probation, etc.)
Reportable Incidents to OASAS (not JC) and appropriate internal agency notification.	
Physical Plant issues leading to incidents	e.g. Door not properly latched, which allows someone on the roof who committed suicide.
Lack of food/ nutrition	
Inadequate Supervision resulting In an incident	e.g. Leading to drug use, violence, sex, etc.
Inappropriate relationships between staff and client	e.g. becoming facebook friends, special favors, exchanging phone numbers or texting, dating, taking client to their home.
Overdose	Service recipient overdose is suspected or the the person was found unresponsive ***(This becomes reportable to the JC if the overdose may be due to staff failure to screen for contraband, do a room check or monitor night security.)***

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

Any ER visit	For injury requiring more than First Aid. Identify triage and treatment. ***(This becomes reportable if the action or inaction of staff contributed to a medical event - ie. Known heart condiction and failure to provide medication; patient's repeated complaints of abdominal pain and staff failure to consider appendicitis or; patient admitted with a toothache which is not addressed and becomes infected.)***
Any First Responder called to a certified site	Includes police and fire dept if 1) there any injuries or harm as a result, 2) was there lack of supervision from staff? Or 3) was there any faulty equipment?
Fire setting	Client action resulting in fire, either deliberate or accidental.