

A close-up photograph of a bright yellow sunflower with a dark brown center, set against a clear blue sky. The sunflower is the central focus, with other sunflowers blurred in the background.

MUI/Abuser Registry Unit

Annual Report

2011

**A review of Health and Safety Systems for
Ohioans with Developmental Disabilities**



Department of
Developmental Disabilities

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The Ohio Department of Developmental Disabilities MUI / Registry Unit is proud to present the 2011 Annual Report. The report has been developed using data compiled from the Incident Tracking System (ITS) for calendar year 2011. ITS is the department's online reporting system for monitoring incidents in each of Ohio's 88 counties. Analyzing data, identifying causes and contributing factors and implementing effective prevention planning is what has allowed Ohio to move forward as a leader in health and safety systems.

Within this annual report you will find data reporting / analysis on a number of the Major Unusual Incident (MUI) categories defined through OAC 5123:2-17-02. The analysis has been completed to assist the department, county boards and providers with identification of systemic issues impacting health and safety for individuals throughout the state. Information pertaining to multiple MUI categories including Physical Abuse, Sexual Abuse, Verbal Abuse, Neglect, Misappropriations, Deaths, Injuries, Hospitalizations, Unapproved Behavior Supports, Attempted Suicide, Medical Emergencies and Missing Persons have been included to assist the field in identifying issues and developing strategies for improvement.

In addition to reporting on specific MUI incident categories we've also provided data related to systemic outcomes. The data includes: 24 hour reporting, 30 day Investigations, Site Visit Reports, Department Directed Investigations, Abuser Registry Statistics, Department Hotline Calls, Pattern Trend Reports, Mortality Review Information and other reports pertaining to the health and safety system.

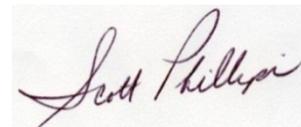
Ten health and safety alerts have been published through the MUI/Registry Unit in 2011. These alerts are developed and shared with providers of service in an effort to get information out to the field about potential health and safety concerns that have been identified statewide. The alerts are created through committee work, pattern / trend analysis and individual case review of incidents. Some sample alert topics include: Falls Prevention, Choking Prevention, Health and Safety is Priority One and Transition Planning.

The MUI Registry Unit reviewed nearly 20,000 reported incidents in 2011. This is an increase of nearly 6% from calendar year 2010. The Department reviews each case to assure that appropriate immediate action has been taken to protect an individual's health and safety.

Ohio provided technical assistance and supports to multiple states around the country in 2011. Topics of discussion include Ohio's web based reporting system (ITS), Abuser Registry System, Mortality Review, and Statewide Patterns / Trends. Each of these elements plays a critical role in improving statewide processes that help protect individuals in Ohio.

The coming year promises to be an exciting one as we look forward to creating better health outcomes for individuals. The MUI Rule OAC 5123:2-17-02 is up for review and some changes have been recommended that will allow the process to operate more efficiently while continuing to protect individuals. Effective reporting, thorough investigations and comprehensive prevention planning will continue to be the pillars for a successful incident management system.

The MUI / Registry Unit would like to thank individuals, families, providers, county boards, constituents and department personnel for their hard work, dedication and commitment to making health and safety a priority in 2011. The Ohio system is comprehensive and requires cooperation and teamwork to gain positive results. When all facets of the system work well together the benefits to those we support are immeasurable.



Each of the 88 County Boards contract for services or employ an Investigative Agent (IA). The IA is required to investigate all reported MUIs. These investigations include the identification of causes and contributing factors as well as prevention plans to help reduce the likelihood of re-occurrence. IAs are certified through the Ohio Department of Developmental Disabilities (DODD) and are required to attend Civil and Criminal Investigatory Practices training and obtain credit hours to maintain their certification.

Providers and County Boards work diligently to ensure that incidents are reported accurately and timely. Working in partnership, providers and County Boards develop immediate actions to ensure the health and safety of any at-risk individual(s). The County Board conducts a thorough investigation for all MUIs entered into the Incident Tracking System (ITS) which includes prevention planning.

DODD is responsible for overseeing a statewide system of supports and services for people with developmental disabilities and their families. The Major Unusual Incident (MUI) Unit plays a critical role by providing oversight to County Boards and Providers to help assure the health and safety of individuals receiving services in Ohio.



The MUI Unit employs fifteen staff and is comprised of three primary entities: Intake, Regional Managers and Registry Investigators.

Intake Managers

- Assure that all MUIs are entered correctly into the ITS system and include effective immediate actions, meet MUI criteria and are classified accurately according to rule.
- Review each and every incident entered into the online Incident Tracking System.

The Incident Tracking System (ITS) is a DODD Application tasked with tracking the Major Unusual Incidents (MUIs) across all of Ohio's Counties. This application aids local and state Developmental Disability (DD) employees in ensuring the health and safety of the individuals we serve. The Abuser Registry is also maintained through ITS and provides a public facing program for employers to check out potential hires before making a determination on whether that employee is in the best interests of the individuals they serve.

Regional Managers

- Oversee Incident management through the online Incident Tracking System (ITS).
- Conduct site visits to Ohio's counties and providers of service as required.
- Provide training and technical assistance throughout the year.



Registry Investigators

- Conduct department directed investigations
- Manage the DODD Abuser Registry
- Conduct site visits to Ohio's counties as required to monitor the quality of the investigation
- Provide training and technical assistance to the Investigative Agents (IA)

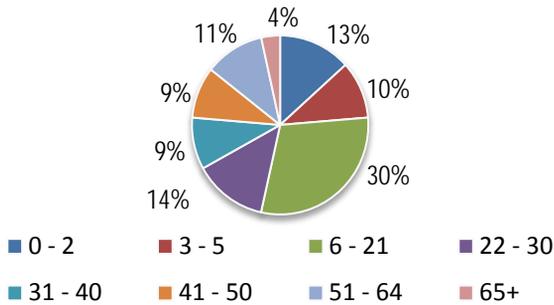
Other statewide functions include: Providing Informational Notices to Stakeholders, Issuing Health and Safety Alerts, Managing a Centralized Complaint Hotline, Conducting Statewide Mortality Review Meetings, Steering Statewide Pattern and Trends Meetings, and providing ongoing training to the field.

The mission of Ohio Department of Developmental Disabilities is continuous improvement of the quality of life for Ohio's citizens with developmental disabilities and their families.

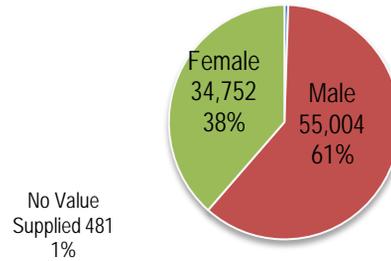


During 2011, over 90,237 individuals with disabilities were served in our system. The services encompassed a wide variety of supports based on need and choice. Individuals between the ages of 6-21 years of age made up the largest group at 30% while those 65 years and older represent the smallest group with 4%. In 2011, the number of men served reached 55,004 while the number of women served was 34,752.

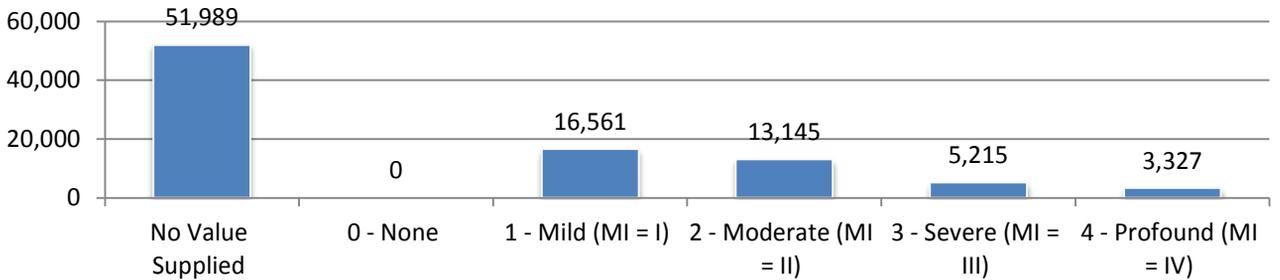
Those Served by Age



Served by Gender

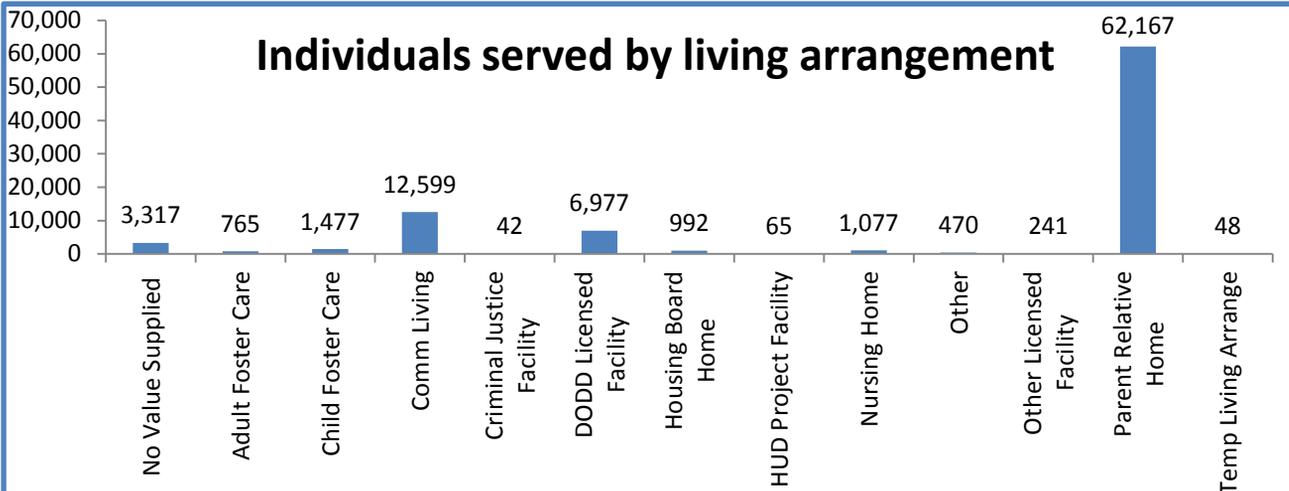


Intellectual Disability Level



Individuals living at home with their parents or a relative continue to make up the largest portion of those receiving services at 69%. Individuals living in the community comprise 14% followed by individuals living in a DODD licensed facility at 8 % of total individuals served.

Individuals served by living arrangement



The Department believes that a caring and well trained work force is critical to providing quality services and ensuring the health and safety of Ohioans with disabilities. Each year the MUI Unit utilizes data that was collected over the previous year to target training. In 2011, the MUI/Abuser Registry Unit provided training to 1856 participants in 43 different trainings across the state. The training was comprised of the following topics and was provided through different sessions and webinars.

Training Topic	Number of Participants
MUI Rule Training	1220
MUI Patterns, Trends and Analysis	372
Advanced MUI Training	119
Misappropriation/Funds Management	65
Civil and Criminal Investigatory Practices	91
ITS and Cognos	38



Additionally, the MUI unit provides daily support to County Boards, COGS and providers. Common areas of consultation include:

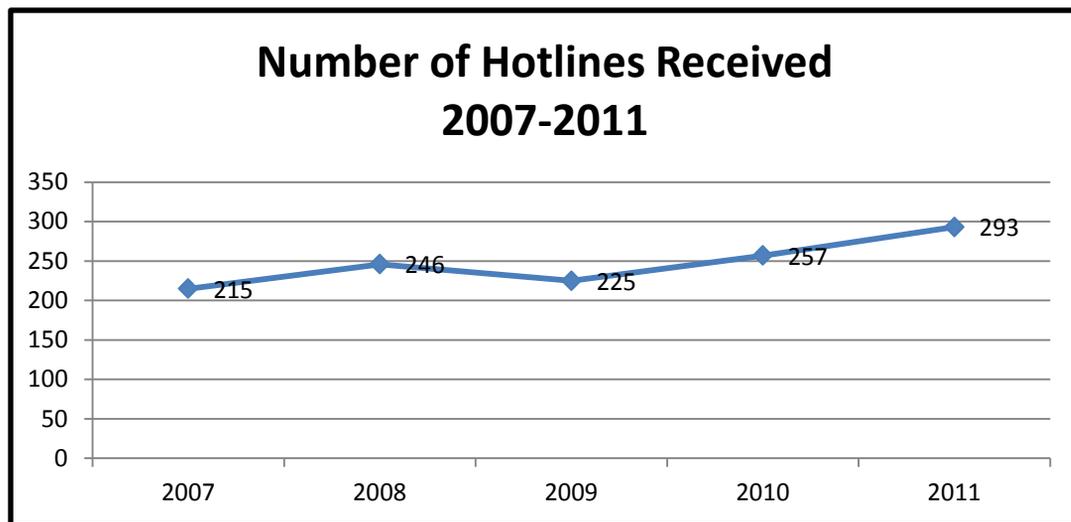
- Department Directed investigations
- Case reviews
- Questions regarding ITS
- Unusual Incident Logs
- How to utilize Cognos Reports
- MUI determinations
- The Abuser Registry process

*Another way that the MUI Unit offers support to our partners is the **Health and Safety Toolkit**. The Toolkit which is located on the Department's website dodd.ohio.gov contains valuable resources for County Boards, Providers, Individuals and their families. The Toolkit contains informational links, training presentations, forms, reference materials and investigative tools.*

The training presentations offered include MUI Rule training, Patterns and Trends, ITS and Cognos. MUI Rule training can be customized for the audience as there is a 2-hour basic MUI rule training geared for Direct Care Professionals and a much longer training for Administrative Staff who may be required to understand all facets of the rule including oversight and analysis.

Some of the most commonly downloaded forms from the Health and Safety Toolkit are the incident report form, unusual incident log and agency analysis. The forms, templates and example sections provide samples for providers and county boards to utilize to meet current rule requirements.

The MUI Abuser Registry Unit oversees the DODD Abuse/Neglect Hotline (866)313-6733. The DODD hotline is one way to report abuse, neglect and theft involving an individual with a developmental disability. Concerned parties may also contact local Law Enforcement when appropriate or the local County Board of Developmental Disabilities to make a complaint. In most cases, contacting the local Board is the quickest and easiest way to lodge a complaint. All complaints or concerns received through the Hotline will be logged and sent to the appropriate Major Unusual Incident (MUI) staff for follow up. When appropriate, that staff will make contact with the person voicing the concern to gather additional information and inform them of the action being taken. In addition, the MUI staff will determine what further action may be needed which may include referral to another entity. In most cases, the incident will be referred to the local County Board investigator. In 2011, hotline calls continued to rise and totaled 293.



In 2011, the Department issued 10 Health and Safety Alerts. These communications focus on areas in which DODD has identified a risk to people and provides guidance about what can be done to avoid or minimize the risk. By rule, all employees are required to review the Health and Safety Alerts issued since last years training. The following alerts were issued in 2011:

- Alert #18-03-11-Choking
- Alert #44-05-11-Transition Issues (Red Flags when changing provider/settings)
- Alert #2-05-11-Keeping Safe in the Summer-Part One
- Alert #2-05-11-Keeping Safe in the Summer-Part Two
- Alert #55-07-11-Medication Administration
- Alert #31-10-11-Preventing the Flu (revised)
- Alert #32-10-11-Misappropriation
- Alert #32-12-11-Bathtub Drowning
- Alert #51-05-11-Health and Safety is Priority One
- Alert #52-11-11-Winter Weather

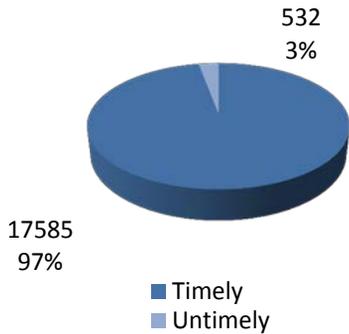


In 2011, the MUI unit conducted onsite reviews of 39 County Boards. The purpose of these visits was two-fold. The first was to monitor the Board's compliance with Ohio Administrative Code 5123:2-17-02 and the second was to provide technical assistance and support in an effort to improve health and safety for the individuals residing within that county.

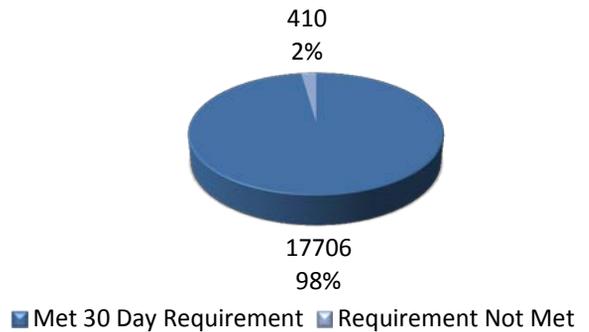
Based on the results of these reviews, County Boards received an award from 1-3 years. Of the 39 reviews completed, 25 counties were awarded a 3 year award while the remaining 14 earned a 2-year award. The MUI unit continues to participate in Accreditation reviews and can conduct reviews at any time. County Boards are held to a high standard of reporting and completing MUI investigations. In 2011, the County Boards continued to achieve high results in these areas. In the area of timely reporting, the County Board achieved 97% overall and 98% in the completion of timely investigations.

Types of County Board Reviews	Number of Reviews
Accreditation	18
Quality Tier	21

24 Hour Reporting



Timely Investigations



The Department's vision is that Ohio's citizens with developmental disabilities and their families will experience lifestyles that provide opportunities for personal security, physical and emotional well-being, full community participation, productivity and equal rights.

Three commonly cited areas of non-compliance at County Board Reviews

Rule Citation/Area of Non-Compliance at County Board Reviews

O.A.C. 5123:2-17-02 Appendix A Investigation Protocol (8)

The I.A. shall interview direct witnesses to the incident and provide documentation of the interviews

O.A.C. 5123:2-17-02 Appendix A Investigation Protocol (14)

The I.A. shall evaluate the relative credibility of the witnesses

O.A.C.5123:2-17-02 (D)(1) Unreported MUIs

All incidents of possible abuse, including misappropriation, or neglect, of any individual, as defined in section 5123.61 of the Revised Code, shall be reported to the local law enforcement entity with jurisdiction and the county board or the to the public children's services agency and the county board. The county board shall report these incidents on ITS and indicate the entity or entities notified.

Providers are key to our service delivery system and it is important that we continue to work together. In 2011, the MUI team provided support to providers through frequent contacts, offering resources on the Health and Safety Toolkit and participating in provider reviews.



among agency providers included:

In coordination with the Office of Provider Standards and Review (OPSR), the MUI unit participated in reviews of certified providers, licensed homes and developmental centers the last year. Using a standardized review tool, providers are measured on compliance with MUI rule.

Some commonly cited areas of non-compliance

Area of Non-Compliance at Provider Reviews

O.A.C. 5123:2-2-01 (C) (2)(e) Abuser Registry Checks

Each independent provider; each member of a family consortium; each chief executive officer or person responsible for administration of an agency provider; and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position shall prior to completion of direct care services shall not be listed on the abuser registry established pursuant to sections 5123.50 to 5123.54 of the Revised Code.

O.A.C. 5123:2-17-02 (M) (7) Unusual Incident Log

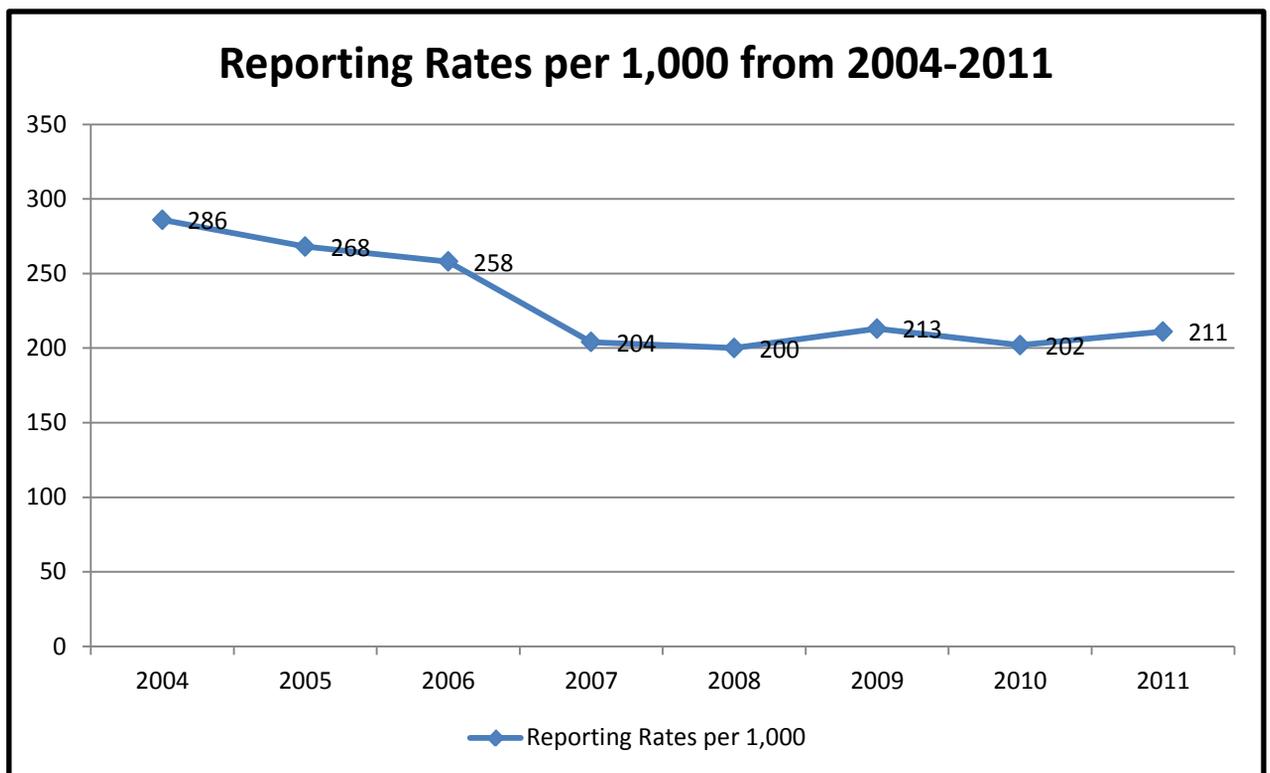
Each agency provider and county board as a provider shall maintain a log of all UIs. The log shall include, but not be limited to, the name of the individual, a brief description of the incident, any injuries, time, date, location, and preventive measures.

O.A.C. 5123:2-2-01 (C) (3) (c) Initial Incidents Adversely Affecting Training

Except for providers of services specified in paragraph (C)(4) of this rule and members of a family consortium, each independent provider and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position, shall meet the following requirements of rule 5123:2-17-02 of the Administrative Code relating to incidents adversely affecting health and safety

A slight decrease in MUI reports occurred in 2007 when there were changes to the MUI rule but overall reporting rates have remained fairly consistent.

YEAR	NUMBER OF MUIs REPORTED	NUMBER OF INDIVIDUALS SERVED	REPORTING RATE PER 1000
2004	20,244	70,702	286
2005	19,973	74,452	268
2006	19,935	77,369	258
2007*	16,247	79,583	204
2008	16,266	81,284	200
2009	17,244	81,022	213
2010	17,703	87,458	202
2011	19,078	90,237	211



Rates reflect the number of MUIs per 1,000 individuals. For example, the unscheduled hospitalization rate for 2011 means that there are 49 MUI reports in this category for every 1,000 individuals served.

Category	2006	2007	2008	2009	2010	2011
Unscheduled Hospitalizations	84.0	48.0	48.5	54.8	49.5	49.0
I/O Waiver	170.4	141.5	132.7	149.7	137.8	141.
Level One Waiver	51.5	16.7	10.6	8.3	9.2	10.
Alleged Physical Abuse	24.7	17.0	16.8	16.7	15.5	16.5
I/O Waiver	53.4	32.6	32.7	33.5	34.3	34.
Level One Waiver	21.7	20.3	16.7	15.5	18.2	18.5
Alleged Sexual Abuse	8.6	5.4	4.7	4.4	3.8	3.78
I/O Waiver	19.1	7.5	6.7	6.5	6.6	5.8
Level One Waiver	9.5	5.3	6.5	5.1	4.4	4.6
Alleged Verbal Abuse	10.0	7.7	7.2	8.7	9.2	9.3
I/O Waiver	28.4	21.5	22.2	24.7	25.9	28.9
Level One Waiver	7.7	7.1	5.2	9.7	10.7	13.0
Alleged Neglect	18.0	17.0	16.5	21.2	21.1	19.5
I/O Waiver	44.1	47.5	52.7	58.0	62.2	67.2
Level One Waiver	6.0	10.0	6.9	8.6	9.4	7.2
Alleged Misappropriations	15.0	15.0	14.4	18.9	21.1	16.37
I/O Waiver	46.1	53.6	61.5	61.4	70.2	71.9
Level One Waiver	9.9	10.5	15.6	16.7	17.7	22.3
Injury	27.0	19.0	19.2	19.5	19.1	18.1
I/O Waiver	57.8	54.2	50.4	47.5	54.2	50.1
Level One Waiver	17.9	8.8	6.5	5.9	7.6	7.9
Death	9.6	8.7	9.3	9.3	8.4	8.88
I/O Waiver	5.9	5.3	5.6	6.2	5.2	7.01
Level One Waiver	2.2	2.1	2.6	1.9	1.9	2.6
Peer to Peer Acts	N/A	24.5	19.1	21.2	22.5	25.4
I/O Waiver	N/A	66.	51.9	50.6	61.1	72.2
Level One Waiver	N/A	25.6	23.6	21.5	24.7	26.2
Unapproved Beh. Support	22.0	20.6	22.6	24.6	20.6	21.1
I/O Waiver	71.8	64.6	74.4	70.2	60.9	59.30
Level One Waiver	15.0	23.3	11.5	16.3	16.3	16.7

** The 2007 data was impacted by rule revisions particularly in the alleged abuse and unscheduled hospitalization categories. In previous years, physical abuse involving 2 individuals was reported under the alleged physical abuse category. In 2007, the rule was changed to file these types of incidents as Peer to Peer Acts. Unscheduled hospitalizations no longer are required to be reported when the person is not with a DD provider/employee.*

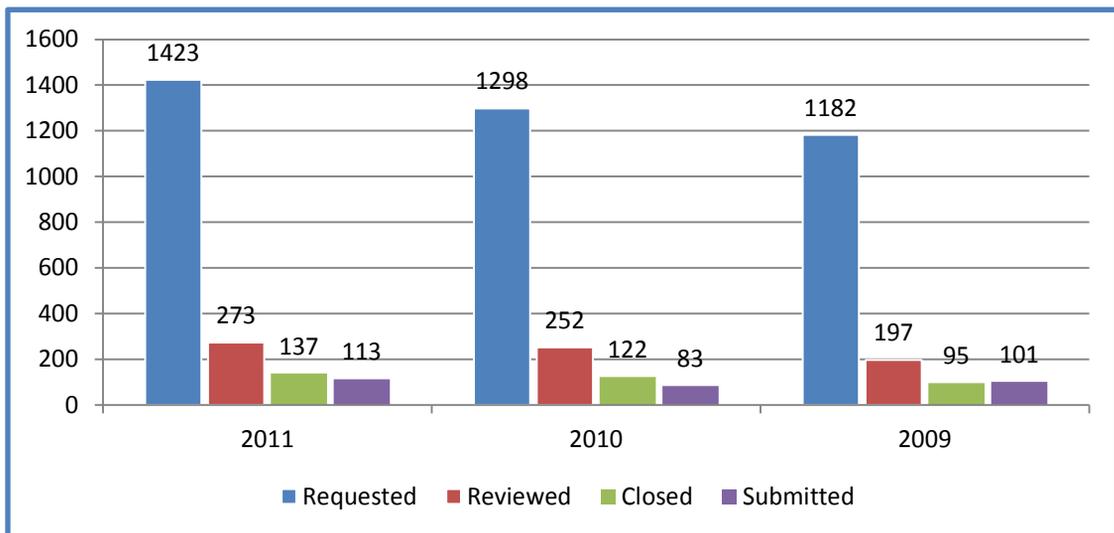


Placement on the Abuser Registry bars that person from employment in the developmental disability field in Ohio. Registry offenses include physical abuse, sexual abuse, verbal abuse, misappropriation, neglect, prohibited sexual relations, and failure to report. The Registry is a safety net protecting all individuals from that person in the future. Placement on the Abuser Registry requires clear and convincing evidence. The Registry is available to everyone on the internet. Anyone can subscribe to have Registry updates e-mailed to them with new placement names. Each year employees receive an annual notice describing all of the potential Registry offenses.

Forty-seven names were added to the Abuser Registry in 2011 for a total of 398 names listed at the end of calendar year 2011. In 2011, there were 1,423 potential Registry Incident Tracking System (ITS) reports reviewed. This initial review is done within 10 days of the closure of the MUI. Approximately 81% of these cases are closed during this initial review.

In 273 of these cases, the MUI/Registry Unit requested and reviewed the complete investigation file. The number of cases initially reviewed for the Registry increased in 2011 by approximately 125 and number of cases requested increased by about 40 cases.¹

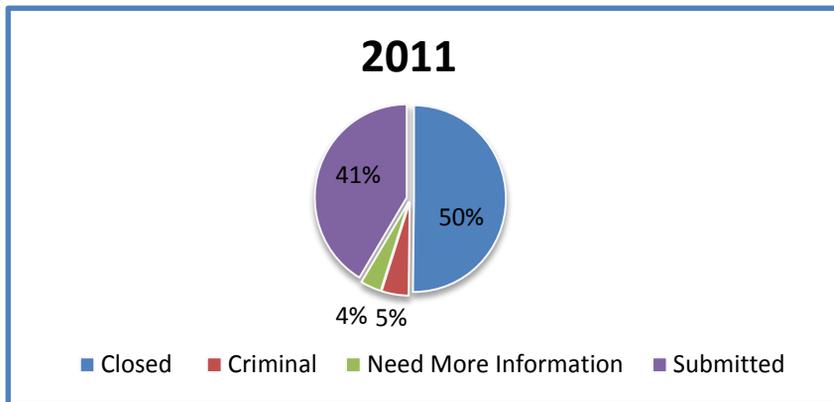
The chart below shows the number of cases for each of the last three years.



There are a small number of cases that require more information or are involved in the criminal process. The Registry does not require a criminal prosecution. If there is pending criminal prosecution, the Registry process must either wait for the criminal process to be completed or get approval from the prosecutor to proceed.² There is a variety of case specific information that must be gathered either through the county board investigation or through the efforts of the Registry Investigators.³

¹In an effort to shorten time frames, when a case is received it is reviewed by the Registry Supervisor before being assigned to a Registry Investigator for follow-up. In 2011, 18% (50 out of 273 cases) were closed by the Registry Supervisor.
² This approval is called a "prosecutor's waiver." In an effort to track and expedite Registry cases, especially those with criminal prosecution, county boards were advised to close MUIs as quickly as possible and note the criminal case information on a specific field within the on-line Incident Tracking System.
³ The MUI Rule sets forth all of the case specific information needed for a Registry case in Appendix A. The Registry Investigators review each county board's MUI investigations (Registry and non-Registry cases) as part of a Quality Tier/Accreditation process.

The best way to improve the Registry process is to improve the quality of the investigations received. That is why an important part of the Registry is to conduct Quality Tier reviews, training, mentoring, and technical assistance to the county board investigative agents conducting the MUI Registry investigations. The chart below illustrates the percentage of actions taken for 2011 Registry cases.



For the 273 cases reviewed for the Registry in 2011, the percentages were similar to 2010 with only a small shift of cases from being closed to being submitted. Last year 54% of the cases were closed and 36% were submitted.

When a case is submitted and does not involve a conviction for the Registry offense, it is reviewed by the External Review Committee. This group is comprised of individuals, their immediate family, county board and provider staff, and victim’s witness groups. The External Review Committee discusses the merits of a case, as well as systems problems and solutions. The Committee makes a recommendation whether there is a reasonable basis for believing that there should be a Registry placement. Each member makes a significant investment of their time and talents. Their advice and counsel is invaluable. The following chart shows the type of Registry placement category:

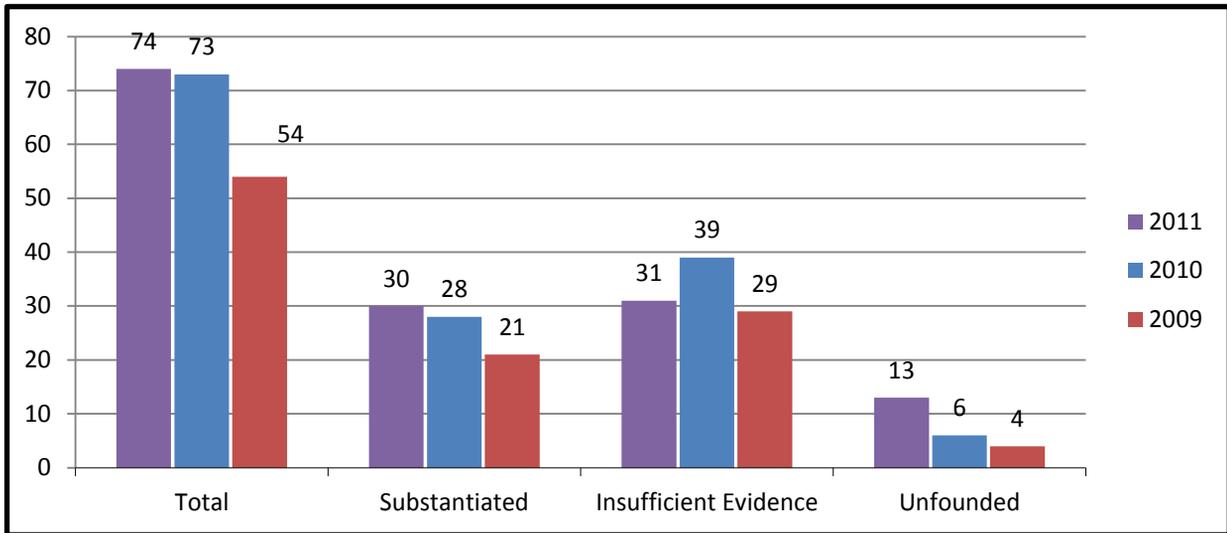
Misappropriation	36
Physical Abuse	4
Neglect	6
Sexual Abuse	1

The neglect cases involved staff members who locked individuals up and left them without needed supervision, didn’t check bath water resulting in serious burns, drove erratically in a car with the individual, failed to obtain timely medical care for an individual, and gave an individual the wrong diet texture resulting in their death.

Twenty-nine (29) of the 47 names placed on the Registry had a criminal conviction associated with the incident. This is one of the reasons that future plans for the Registry incorporate the use of the criminal outcome field on the on-line Incident Tracking System and education and collaboration with prosecutors. Continued improvements in MUI investigations and communication with law enforcement will help to reduce unnecessary processing delays. The MUI/Registry Unit works with each county board in closing the Registry cases and also in the Quality Tier Review to maintain quality investigation standards.

Ohio Revised Code Section 5123:2-17-02(I) describes the allegations in which the MUI/Registry Unit is required to conduct a Department Directed Investigation. It would be a conflict for the county board or developmental center to conduct the MUI investigation. There are also cases in which the individual, a family member, a provider, or the county board requests that the Department conduct the MUI investigation. In 2011, there were 69 investigations conducted. Some investigations contained more than one allegation, the total number of allegations in 2011 was 74.

Below is a chart with the findings for each allegation:



The chart below shows the substantiation percentage for the last three years.

	Substantiated	Insufficient Evidence	Unfounded
2011	41%	42%	17%
2010	38%	54%	8%
2009	39%	54%	7%

47% of the investigations were completed within the timeframes without an extension. The rest of the investigations (53%) were completed within the extension timeframes.

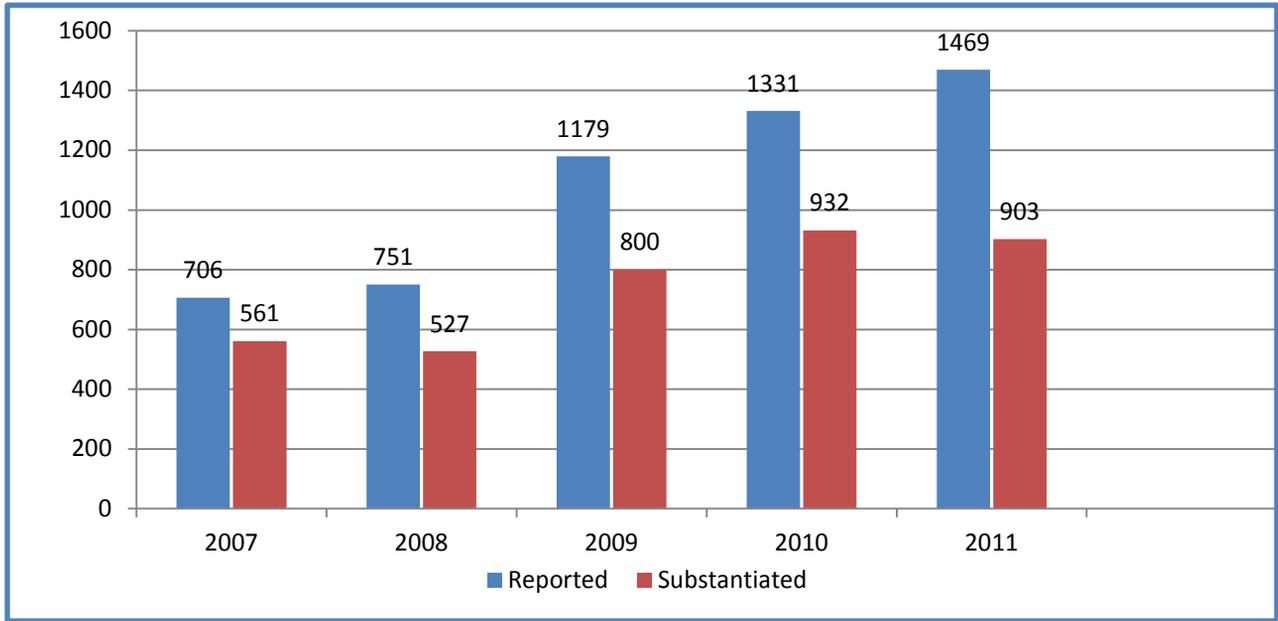
The numbers for allegations and substantiation rose in Verbal Abuse, Exploitation and Failure to Report categories. While there were more allegations of Neglect in 2011, there were fewer cases that were substantiated. As in 2010, there were cases in which the Failure to Report allegation was unsubstantiated and there were still recommendations to improve the systems involved in reporting and responding to a major unusual incident.

The chart below shows the type of allegation and whether it was substantiated for the last four years.

Allegation	Total Investigated	Total Substantiated
Failure to Report 2011	19	9
Failure to Report 2010	17	7
Failure to Report 2009	9	3
Failure to Report 2008	10	7
Neglect 2011	27	12
Neglect 2010	24	17
Neglect 2009	22	14
Neglect 2008	19	12
Physical Abuse 2011	4	0
Physical Abuse 2010	8	2
Physical Abuse 2009	5	1
Physical Abuse 2008	10	0
Prohibited Sexual Relations 2011	1	0
Prohibited Sexual Relations 2010	3	1
Prohibited Sexual Relations 2009	1	0
Prohibited Sexual Relations 2008	2	0
Rights Violation 2011	1	0
Rights Violation 2010	1	0
Rights Violation 2009	1	0
Rights Violation 2008	1	1
Sexual Abuse 2011	9	0
Sexual Abuse 2010	4	0
Sexual Abuse 2009	9	0
Sexual Abuse 2008	11	0
Verbal Abuse 2011	9	5
Verbal Abuse 2010	8	2
Verbal Abuse 2009	6	3
Verbal Abuse 2008	5	1
Misappropriation 2011	2	1
Misappropriation 2010	2	0
Misappropriation 2009	0	0
Misappropriation 2008	3	0
Exploitation 2011	5	3

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

In 2011, there were 1469 reported allegations of misappropriation and 903 incidents were substantiated.



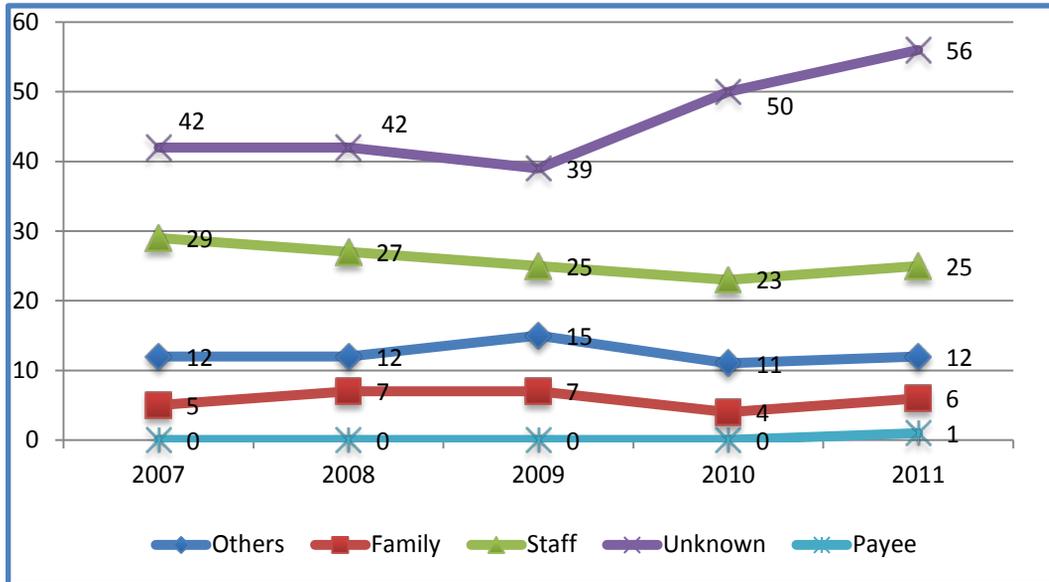
The percentage of cases substantiated in 2011 was 61% percent which was a decrease of 9 % in substantiated rate from 2010 (70%). Overall, statewide misappropriation allegations have increased slightly in all areas. The largest increase is found in the substantiated cases where the PPI is unknown. This category rose from 50% in 2010 to 56% of all cases in 2011. The rate of cases for unknown PPI is concerning and is being addressed system-wide through the following remediation steps:

- A Misappropriation Health and Safety Alert (#32-10-11) was issued in October 2011.
- A committee of Department staff and various stakeholders was formed with the purpose of providing guidance and support to the field regarding funds management and misappropriation prevention. Forms such as funds transaction records, inventory and gift card tracking were developed and made available on line in October 2011. Resources (training, forms, and guidance) were posted on the MUI Health and Safety Tool Kit at <http://dodd.ohio.gov/healthandsafety/Pages/Money-Management-Folder.aspx>
- An Information Notice was issued to all County Boards, Provider, and COGS on October 13, 2011 outlining sound money management practices.
- Money Management and Misappropriation trainings were offered to Investigative Agents, County Boards and self advocates.

Year	Reported	Substantiated	Percentage
2007	706	561	79%
2008	751	521	70%
2009	1179	800	69%
2010	1331	932	70%
2011	1469	903	61%

The following charts illustrate what items were commonly taken and by whom.

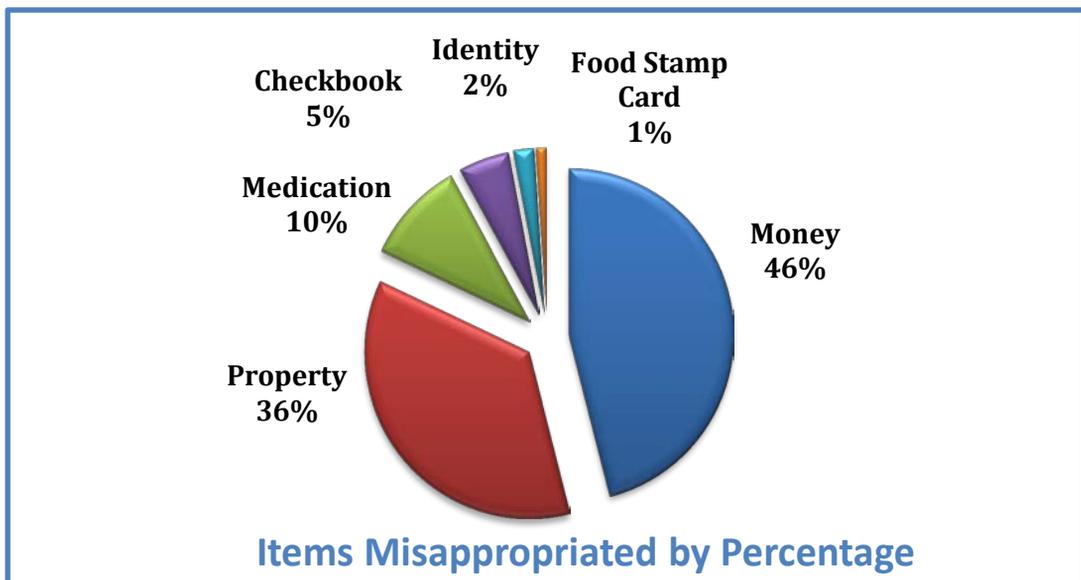
Percentage of Misappropriation Cases by PPI type



Law Enforcement was notified in all appropriate instances and conducted a formal investigation 18% of the time. They took a report for all of the remaining cases.

Items Misappropriated in 46% of the substantiated cases the item stolen was money, 36% of the cases involved property and 10% medication theft. Identity, credit/debit cards and utilities represented about 3% each of the items stolen.

Location of Misappropriation 78% of the substantiated incidents occurred in the individual's home, 13% occurred while out in the community, and 4% occurred at work. This data is fairly consistent with the 2009-2010 data



Causes and Contributing Factors:

- Little oversight for lump sum payments
- Individual's homes are left unlocked for staff convenience. In several cases, individuals and staff have left their homes and within an hour, all items of value (even some well hidden in back of closets) have been taken from their home.
- Personal property (I-Pods, Gaming Systems and Laptops) are not secure
- Individuals are vulnerable to theft by people in the community
- Medications are not being counted per agency's policy
- No auditing system for checking purchases that are made and to assure receipts are accounted for especially after large purchases
- Employees are allowed to keep shopping money for long periods of time
- No accounting for ongoing payments such as burial plans and/or life insurance policies
- Burial accounts and life insurance deposits are handled by one person who may be taking money intended to pay these accounts
- Social networking has increased and so have opportunities to be taken advantage of on-line
- Gift cards are purchased but are not tracked and often come up missing
- Trusted Employees, Family members, Payees have access to credit cards, bank cards, and personal information with little oversight
- Individuals rely on family and/or caregivers to do the banking (Deposits / Withdrawals)
- Money storage (Safes, lock boxes, and folders) aren't secured or too many people have access

Prevention Planning:

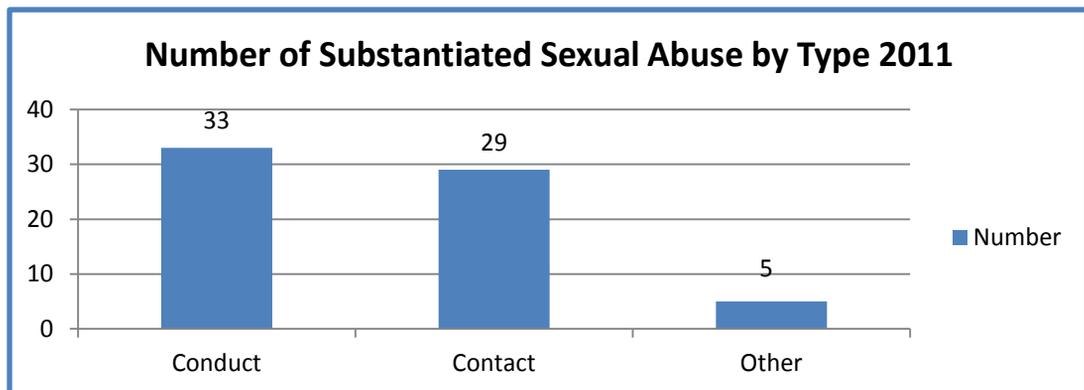
- Secure methods for storing cash, checks, medication and property appropriate for the person served
- Safety Skills reviewed with individuals
- Carefully review all incoming bills to ensure that only purchases made by individual are being charged to them
- Complete Routine Credit Checks (many are free)
- Minimizing the number of staff with access to medication and cash on hand
- Oversight of those responsible to manage and monitor money in the homes
- Regular reconciliation of accounts including obtaining receipts and matching them up to actual purchases
- Ensure windows, doors and garages lock properly
- Check that medications are accounted for on each shift
- Discuss trips and other large expenditures in advance with the team
- Ensure that individual's personal information such as social security number, date of birth and Medicaid/Medicare numbers are not left out where someone else could take and use
- Be cautious when applying for lines of credit or opening new accounts



There are three types of Sexual Abuse MUI allegations: Conduct, Contact, and Other. Conduct is the most egregious and would include any type of rape, oral sex, or penetration. Contact is touching breasts or genitalia either over or under clothing. Other would include voyeurism, taking pictures of the individual, promoting prostitution, and anything else that would not fit the category of conduct or contact.

Sexual Abuse MUIs are also broken down into categories of who is alleged to have committed the act. MUIs result in a finding of either substantiated or unsubstantiated. The standard for substantiation is preponderance of the evidence. This means that it is more likely than not that there was sexual abuse. In the category of MUIs, not involving another individual as the aggressor (Non-Peer), there has been a decrease in the number of substantiated cases of both sexual conduct and sexual contact.

Year	Allegations	Substantiated	% Substantiated
2009	345	83	24%
2010	328	81	25%
2011	333	67	20%



Break Down by PPI	Number	Percentage
Family	16	24%
Other	41	61%
Unknown	6	9%
Staff	4	6%

Please note that this year's report includes a section for Peer to Peer Acts and therefore above data does not include peer to peer sexual acts.

Individuals told others later that they were afraid to report the assault(s) because they were threatened with job loss, losing their home, or being hurt again. Individuals are scared that the abuser knows where they work, what bus they ride, and where they live. They describe being stunned, embarrassed, and not wanting their boyfriends/girlfriends to know. Initially, some individuals have disclosed in what others described as a “matter of fact” way the assaults. One survivor describes how, “this stuff happens to people” when describing how she was raped. There are all sorts of reactions and one individual was hospitalized right after the attack because she voiced that she was suicidal.

Focusing on the 49 substantiated conduct cases – both Sexual Abuse shows that disclosure of the sexual assault ranged in time from more than a year later during counseling to minutes after the assault. There were a few cases in which the individuals were not able to disclose the sexual assault and it became evident from physical signs: vaginal bleeding, bruising, chlamydia, or pregnancy. Immediate actions included separating the victim from their attacker – at home/work/transportation. Staff were placed on administrative leave and several attackers were arrested right then. One individual requested an extra patrol in her area and got a phone. Many of the cases involved the individual considering a SANE examination. Law enforcement then used that DNA evidence in confronting the suspect. The category of non-peer substantiated conduct cases were investigated by law enforcement at the highest rate of any MUI at 87%.

Only three of the substantiated conduct cases involved someone who was unknown to the victim; 93% of the time the victim knew their attacker.

Counseling offered for the survivor and in peer to peer cases, the abuser after the event is a common immediate action and long term support. Education in terms of sexuality and also abuse awareness would reduce the risk of sexual assaults. Nora J. Balderian, Ph.D wrote in her book, *Interviewing Skills to Use with Abuse Victims Who Have Disabilities, May 2004:*

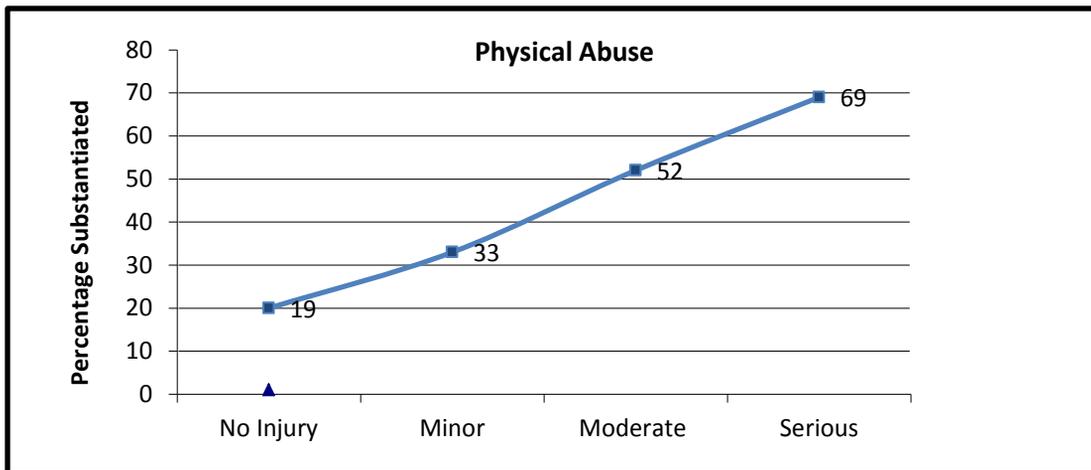
. . . Teaching abuse awareness and risk reduction strategies is similarly avoided as the discussion would demand information on sexual issues. As a result this most vulnerable population becomes even more vulnerable through lack of appropriate education, training, and preparation. This is representative of ‘mixed thinking’ that is common when addressing issues that people with disabilities face. In this case, it is assumed that assault and sexuality fall into the same category! This is akin to placing robbery or burglary in classes on budgeting or financial management. . .

All reports of sexual assault should be taken seriously and the response, especially of the person to whom it is first disclosed, should support the survivor.

Physical abuse means the use of physical force that can reasonably be expected to result in physical harm. Since 2007, incidents have been split up into two different types of MUIs depending on the aggressor. If the incident involves another individual with developmental disabilities, it is listed as a Peer to Peer Act. The 2011 annual report includes a Peer to Peer Act section that will address those incidents.

In 2011, there was slight increase in the number of physical abuse allegations reported from last year: 1,456 to 1,497. This increase is offset by the increased number of individuals served. The rate of reporting per 1,000 had a slight increase from 15.5 to 16.59. The number of cases substantiated based on a preponderance level (it is more likely than not the abuse happened) went from 429 to 412. This also had a corresponding dip in rates per 1,000 of 4.91 to 4.57. The percentage of allegations that result in a substantiated finding has been consistently at 27%-28% over the last three years. Since Ohio is gathering reports on cases with a reasonable risk of harm standard, many cases have no injury. In 2011, there were a total of 1,497 allegations made of physical abuse. In 33% of these cases there was no injury; in 49% of the cases there was a minor injury.

The chart below shows the substantiation percentage based on the level of injury and how as the injury level rises so does the substantiation percentage.



Law enforcement was notified in 735 of the cases; took a report in 315 cases, and investigated the allegation in 447 of the cases.

There were 412 substantiated cases of physical abuse (non-peer) that did not involve an individual as the aggressor. Of these cases the abuser falls into one of five categories:

Break Down by PPI	Number	Percentage
Family	114	28%
Other	113	27%
Staff	111	27%
Unknown	66	16%
Guardian	8	2%

Red Flags of Abuser

- Prior history of abuse/neglect
- Prior criminal history of assault/domestic violence
- Prior criminal history of drug trafficking/theft
- Under influence of alcohol and/or drugs
- Enforcer mentality – control struggles
- Isolating individual
- Stealing from the individual
- Impatience
- Verbally abusive - demeaning

Causal factors listed in physical abuse cases are similar to last year's factors. The abuser was stealing from the individual. Individuals were told to keep quiet and not disclose that the abuser had stolen their money, property, or medications. Intimidation and physical violence were a part of controlling the individual and allowing the abuser to continue to steal from them. In some cases, conditional verbal threats either accompanied or preceded the assault. The abuser was frequently seeking to dominate and control the individual in every aspect of their lives. Individuals were threatened that they would be hit again if they told. There are a small number of cases in which the individual's choice to engage in high risk activities carries with it increased risk of being around violent abusive people.

Another red flag is when the abuser isolates the individual and doesn't want them to see a doctor, other staff, or family and friends. Many of these abusers target certain individuals and claim afterwards that the individuals' behaviors drove them to a breaking point. Some cases have the aggressor taunting the individual to "hit me again" or "say that again" and see what happens. Even when the aggressor could easily avoid being hit (the individual uses a wheelchair) or move to another room, they confront the individual and hit them.

Other red flags would include the individual being afraid of the abuser. The individual is reluctant to go home or be around a certain person. They may become instantly compliant; fearing the consequences of breaking a rule. They are afraid that they will be in trouble if they tell about the abuse. Abusers in these cases point to the actions of the individual after the abuse (apologizing, acting as if nothing happened, hugging the abuser, telling other people that they – the individual – was at fault) as a sign that they did not abuse the individual.

Reducing the risk of physical abuse involves creating an environment that does not tolerate violence. Battles for control and demeaning words or actions are not acceptable. Safety planning and promoting an individual's awareness of their rights and the need for everyone to report these incidents is important. Accountability of the individual's funds and property, including medications, will help stem the violence surrounding the thefts. All disclosures must be taken seriously. Criminal prosecution, removal of custody, appointment of guardians, background checks for hiring including checking the Abuser Registry, will help prevent future incidents. It is also critical to consider what supports might be helpful for the survivor after the trauma.

According to the National Crime Victimization Survey, 2008 published by the U.S. Department of Justice in December 2010, persons ages 12 to 24 and ages 35 to 49 with disabilities were nearly **twice** as likely as persons in these age groups without disabilities to be victims of violent crime when comparing rates that were not adjusted for age. The study also indicates:

- About 15% of violent crime victims with disabilities said that they suspected that they had been targeted due to their disabilities
- Among persons with disabilities, females had a higher risk of violent crime than males (after adjusting for age) in 2008
- About a fifth of violence against persons with disabilities involved an offender with a weapon
- 27% of violent crime victims with disabilities were injured as a result of the crime; 11% sought treatment
- Violent crimes against about half of all victims were reported to the police in 2008, regardless of the victim's disability status
- Household burglary made up a higher percentage of all property crime against households with persons with a disability (25%) than against households without persons with disabilities (19%)
- Property crime (overall property crime, household burglary, and motor vehicle theft) against households with persons with disabilities was less likely to be reported to police than when it was committed against households without persons with disabilities



How does Ohio compare?

- According to 2011 data, females were the victim of physical and sexual abuse more than their male counterparts.
- Males were the victim of misappropriation allegations 15 % more than females in 2011.

Did you know...

Ohio Revised Code 2913.02 has felony enhancements for Theft and Exploitation crimes when the victim is an elderly person or individual with a disability.

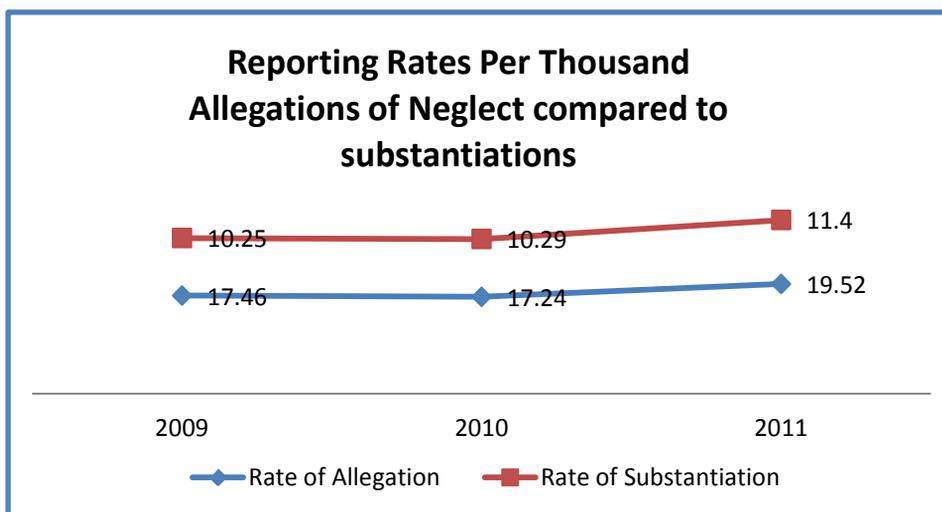
“Neglect” means when there is a duty to do so, failing to provide an individual with any treatment, care, goods, supervision, or services necessary to maintain the health and safety of the individual. Neglect MUIs do not require that there be a resulting injury, they do require that there is a reasonable risk of harm.

All Neglect MUIs require immediate action, an administrative investigation to determine causal factors, and prevention plan implementation. These three elements are addressed in each and every case.

The MUI investigation results in a finding of unsubstantiated or substantiated. The standard for a finding of substantiation is by a preponderance level – it is more likely than not that the neglect happened. There were a total of 1,030 substantiated cases of neglect in 2011. The chart below shows the reporting and substantiation numbers and the substantiation percentage over a three (3) year period:

Year	Allegations	Substantiations	Percentage of Substantiations
2009	1415	831	58%
2010	1510	901	60%
2011	1762	1030	58%

While the total number of reported and substantiated cases has grown over the last year, the number of individuals served has grown as well. To better understand the context of the number of MUIs, the rate per 1,000 individuals of both reported and substantiated cases of neglect are shown below:

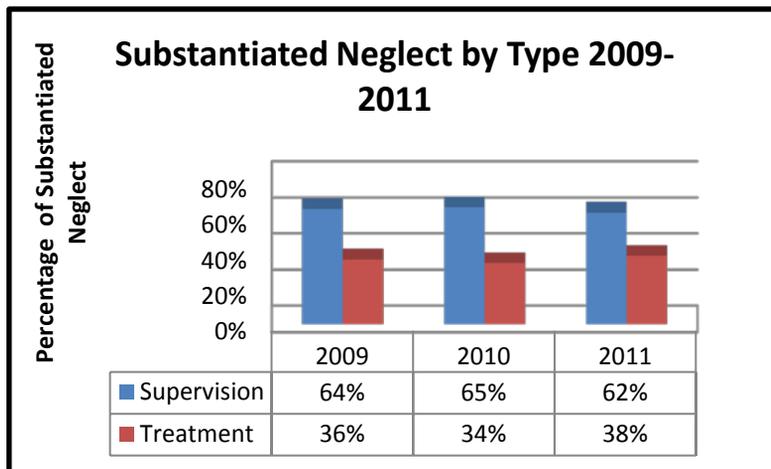


This would mean that in 2011, 19.5 people out of 1,000 would have an allegation of neglect reported. In 2011, there would be 11.4 people out of 1,000 with a substantiated MUI of neglect.

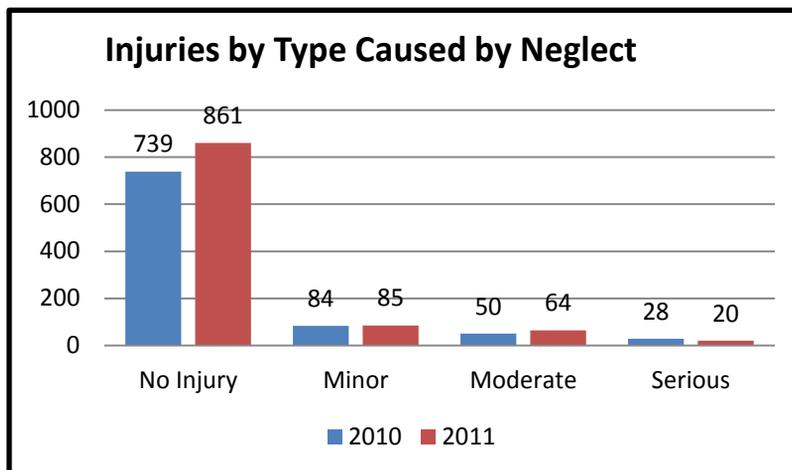
The chart below breaks down into a percentage the person(s) responsible for the substantiated MUIs:

	<u>2011</u>	<u>2010</u>	<u>2009</u>
Staff	83%	70%	66%
Family	10%	8%	16%
Systems	7%	14%	11%

Each individual's plan outlines the services and supports needed to avoid specific risks. Neglect MUIs are broken into two main categories: supervision and treatment. For example, some individuals have a history of swallowing or inserting items that are dangerous and need someone to intervene. This person would need a supervision level to address that need. The other category of neglect MUI is a failure to provide treatment. An example of treatment would be an individual needs to be assisted in moving to avoid them developing a pressure ulcer. The chart below shows the breakdown of substantiated MUIs for the last three years by supervision and treatment category.



The numbers of allegations filed, percentage substantiated, the rates per 1,000, and the percentages of supervision vs. treatment neglect have remained fairly consistent for the last three years. There has been a decrease over the last two years in the number of individuals sustaining a moderate injury that have a substantiated MUI of neglect. As this chart shows the total number of injuries in substantiated neglect MUIs have decreased over the last year. Minor injuries have a slight increase, serious injuries have remained about the same and there is a decrease in the number and rate of moderate injuries.



Injuries are defined as the following:

Minor – Did not affect day-to-day activities, e.g., broken toe, fingers, sutures, splint, wrap.

Moderate – Did affect day-to-day activities, e.g., missed work, crutches, casts, adaptive equipment, bed rest.

Severe – Injury required hospitalization, off weeks from work.

None – no injury.

Serious Injuries resulting from Neglect

The following is a summary of some of the Neglect MUIs that involved serious injuries. Any case involving a death would be reviewed in detail by the Mortality Review Committee.

- Individuals choke with improper dietary textures and pacing. The individual is not able to safely swallow the type/amount of food they have eaten. Not preparing the right dietary texture for the individual has led to choking, aspiration, and even death.
- Staff did not monitor temperature of water; individual is covered in severe burns. Delay in medical attention.
- The individual's wheelchair was not properly tied down.
- The individual fell when being transferred because there was not adequate staff to assist with the Hoyer Lift. The individual suffered a broken leg.

Contributing Factors in Substantiated Neglect MUIs

Caregiver Concerns

The caregiver knows and callously disregards the needs of the individual so the caregiver is at fault. Instead of providing the supervision or treatment needed, they choose to do their own shopping, get drunk, text on their phone, leave the individual alone to go to another job, watch television, and an assortment of other things for their own personal enjoyment. The common element in these cases is that the caregiver completely ignores the individual and their needs. The caregiver may try to limit the individual's contact with others to cover up the neglect. There may not be a doctor or dentist appointment for years. The neglect may be accompanied by misappropriation, verbal abuse, and physical abuse. Some preventative measures for these cases involve criminal prosecution, removing the individual from their care, appointment of a guardian or a new guardian, respite care, and placement on the abuser registry.

Distraction / Complacency

These are the cases in which other people or things compete for the caregiver's attention.

- A person turns away to get an attends during hygiene and the individual falls.

Distraction / Complacency

- Supervision levels are not met because of the staff doing laundry instead.
- Certain safety steps are not taken or are not done in the right order.
- Shortcuts are taken to speed things up in using lifts, bed rails, and wheelchairs.
- People have fallen off van lifts, wheelchairs have tipped, gait belts, helmets are not used, leading to injury. People are dropped off early/late with no supervision.
- Cases in which complacency is a factor involve experienced caregivers who become accustomed to nothing happening. The day in, day out schedule and how well everything is going, lulls them into not following the individual's plan. The caregiver may decide to sleep instead of providing needed supervision.
- *This would also include employees working multiple shifts without a break or rest.* The overall schedule may not provide proper staffing

Miscommunication or Lack of Communication

- There is an underlying false assumption on the part of the caregiver. Who is responsible for the individual's supervision level at the time of the incident?
- There is no clear method of transferring supervision between employees. It also is a factor in knowing exactly what supervision level is needed for the individual in all settings.
- There is a failure to listen to the individual or those people in their lives that know them best. When someone describes the individual as not themselves, acting funny, or in pain, it is attributed to a behavioral issue. Discounting this information causes a delay in medical attention.
- Gaps in implementing physician orders, getting and refilling medication orders, changing the medication logs, and giving the correct medication are sometimes issues of miscommunication.

Transitions

- Changing schedules or changes to where the person works or lives are always times of increased risk. There may not be the environmental supports in place at the new locations.
- Changing pharmacies has been a risk factor in many of the substantiated treatment neglect cases. The person may stay in the same location and still have changes.
- They do not have the proper equipment for those changes. The lift straps no longer fit the individual correctly.
- There is no food processor to prepare the right dietary texture for the individual.
- There have been special events that cause a break in the individual's schedule: camp, Special Olympics, dances, and vacations. Even something as common place as going on and off a bus are times of transition.
- Changes in caregivers can present an increased risk. When a family member dies, the new caregiver is not only learning how to care for the individual, but are attempting to work through the grieving process.

Lack of Action (Attention to Detail)

- The caregiver is trying to help the individual but lacks proper judgment. They see signs and symptoms of an emergency, but fail to call 911 immediately. The approach of let's wait and see or call someone else is dangerous. Many times a nurse will instruct the caregiver to monitor vital signs and communicate concerns. Some caregivers do not understand vital signs and what is considered within normal range. Therefore, they do not act upon critical information that an individual is in distress and only make contact with the nursing staff when the individual starts to exhibit other serious symptoms. Often it is too late and there has been a delay in care which is life threatening.

Prevention

1. Remove caregivers who, knowing the possibly tragic consequences, neglect individuals. The most egregious of these would also qualify for criminal prosecution for neglect.
2. Explore whether having a guardian or having a new guardian would be appropriate.
3. Provide training to caregivers on individual's risk factors. Assure the caregiver has the tools to effectively intervene when there is a risk to health and safety.
4. Listen to the individual and to those who know them the best. Is this unusual behavior for them? Do not disregard their complaints of pain or injury as attention seeking. Advocate for the individual if a need is being unmet. Have a clear system of documenting and implementing continuing and changing medical needs.
5. Have all materials/equipment needed for the individual and for each task. Make sure all equipment is in good order and properly used by caregivers.
6. Build in a system of checks and balances to ensure medications are ordered, refilled, and taken properly.
7. Be aware of and plan for dangers during transitions (residential, day program, vacations, and respite).
8. Know and follow dietary textures and pacing – in all locations and on special occasions. Plan ahead.
9. Individuals that have specific medical needs should have caregivers that understand the signs/symptoms for that condition. Examples would be a heart condition, deep vein thrombosis (blood clots), diabetes, blood thinners, respiratory problems, and seizures. Call 911 immediately, if needed. Do not tie caregiver's hands with mandatory notifications prior to calling 911. If there is any doubt, call 911. Make sure caregivers are educated on the signs and symptoms of serious illness. Please see Health and Safety Alert –Health and Safety is Priority One.
10. Plans should be current and consistent across all settings. These should include clear expectations of how to respond to this individual and their unique needs.
11. Wheelchairs, lap belts, gait belts, shower chairs, van lifts, and other assistive devices and transfers should have a standardized best practice way used by all caregivers. Hands on training should be consistent with this simple and understandable best practice.
12. Plan for staffing difficulties. As much is possible, have experienced caregivers teach and mentor less experienced caregivers about the individual's needed services.

Systems Neglect

When an individual is neglected and the neglect is not the result of a particular person/people, a systems neglect is identified. A systems issue is a process that involves multiple components and has played a role in the neglect. For example, a person does not receive medication timely because the pharmacy thought the nurse was going to pick up the prescription. Yet the nurse believed the pharmacy was delivering the prescription. There was no specific policy outlining how this situation should be handled. Neither party was neglectful, however the individual did not receive his medications timely. As a result, there was systematic changes that needed to be made to prevent this from occurring in the future. Prevention plans for systems issues involve policy changes, changes in procedures, training and oversight to effect positive changes.

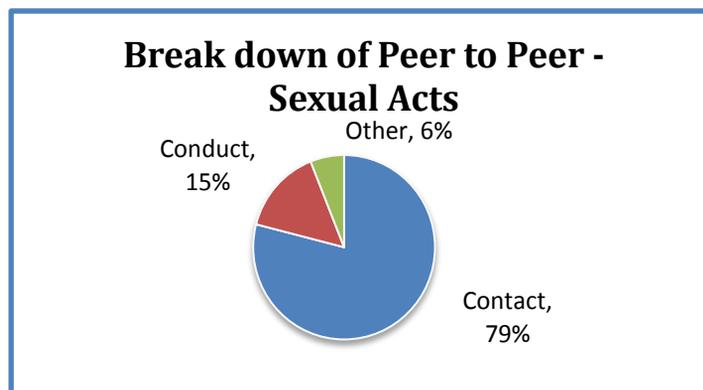
"Peer-to-peer acts" means acts committed by one individual against another when there is physical abuse with intent to harm; verbal abuse with intent to intimidate, harass, or humiliate; any sexual abuse; any exploitation; or intentional misappropriation of property of significant value.

Since 2007, peer to peer acts were separated from other MUIs in which non-peers were abusive or misappropriated the property of another individual. The different coding acknowledges the unique nature of having to serve and support both individuals – the aggressor and the victim. While not minimizing the injury and/or risk to the victim, it also acknowledges that immediate actions and preventative measures may be different. Peer to peer incidents are typically witnessed by a paid support and therefore have historically been substantiated at a higher rate than non-peer cases. Allegations of Peer to Peer acts are on the rise as illustrated by the chart below:

Allegation	2009	2010	2011
Physical	1076	1234	1433
Sexual	295	307	341
Verbal	187	236	397
Misappropriation	118	134	127

Analysis:

- There was a 14% increase in Peer to Peer Physical Incidents however in 24 % of cases there was no injury and 41% resulted in minor injuries. I.e. scratches.
- Incidents involving Peer to Peer Sexual comprised 341 of allegations and 31% (107) of these were substantiated.
- The total number of substantiated sexual abuse MUIs has remained consistent in the Peer category. While it does show a slight increase, there has also been an increase in the number of individuals served from last year.

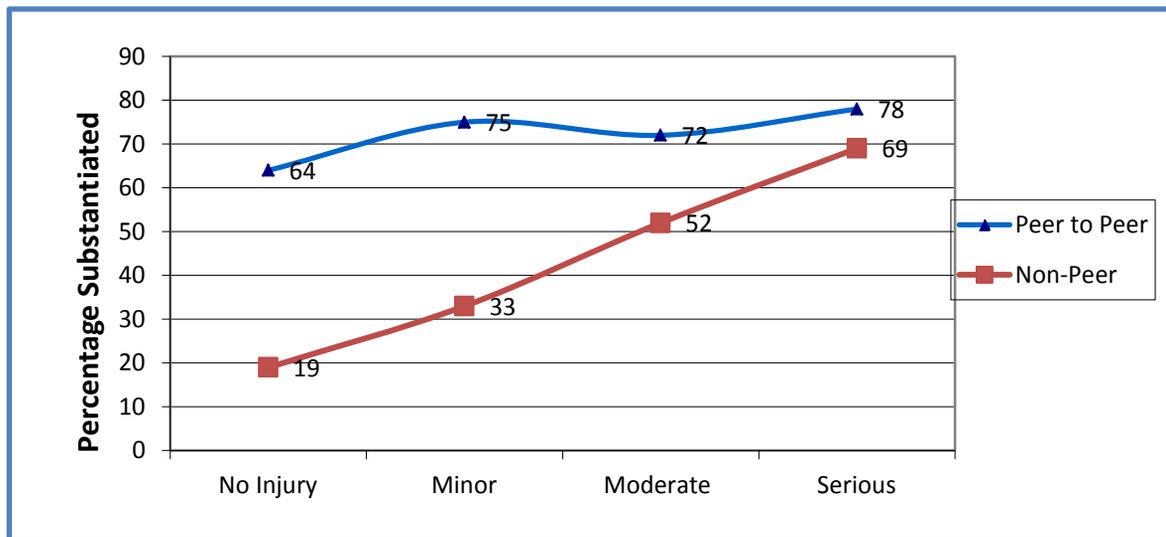


"Sexual contact" means any touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person.

"Sexual conduct" means vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse.

Physical Acts

There were 1,015 cases substantiated at a preponderance level (it is more likely than not to have happened) in 2011. Last year the total peer to peer substantiation percentage was 70%, this year it is 71%. Peer to peer physical acts have historically been substantiated at a higher rate than cases of Physical Abuse. The chart below shows the substantiation percentage for both types of MUIs with corresponding injury levels.



Law Enforcement

There were 1,433 allegations. Law enforcement was notified in 642 cases; took a report in 244 of the cases, and investigated the allegation in 81 of the cases. In 2011, 469 of the cases did not rise to the level of a criminal allegation in peer to peer cases.

Physical Acts - Cause and Contributing Factors

Between discovering what happened and what can be done to lower the risk of it happening again in the future is the question of why. Why did this happen? Cause and contributing factors are a part of every physical abuse MUI. Documented cause and contributing factors have improved through the years. In 2008, 30% of the MUIs were without a documented cause or contributing factor. There was either none noted or it was listed as unknown. Many of the rest of the cases answered the question of why with non-useful generalities.

As can be seen from the chart below the Unknown category has shrunk.

Year	Unknown
2008	30%
2009	15%
2010	5%
2011	3%

The cause and contributing factors continue to improve in their level of detail and thoroughness. Even those MUIs that now conclude without a known cause or contributing factor(s), have determined with more specificity what happened. The team for the aggressor in many of these cases have explored what factors were ruled out and documented what steps have worked/not worked. The common causal factors have remained consistent over the last three years. This list of common factors is not offered to condone the aggression or to in any way suggest that the victim is to blame. It is offered to try and trace back the root causes and prevent future incidents.

Aggressors are aggravated by the perceived actions of the other individual:

Thinks that individual has stolen, taken, broken their property
Being "bossy"
Talking loudly, asking a lot of questions
Taking over their work at home or the workplace
Touching them – even accidentally
Talking about their relationship with ex-boyfriends/girlfriends
Won't let them sleep;
Radio, television, music choices
Other individual came into their room personal space
Joking or horseplay misinterpreted
Thinks they are defending staff or staff's children

Aggressors are frustrated and stressed about other things:

Grief over loss of family member
Change to schedule/routine
Worried about future medical appointment
Worried about going on trips/visits
Loss of liked staff member
Not being able to attend event
Not able to have specific food/drink
Not having fulfilling work

Aggressor feels excluded and seeks attention:

Staff is paying attention to someone else
Not able to sit with others at lunch
Boyfriend/Girlfriend break up or paying attention to someone else

Aggressor specific reasons:

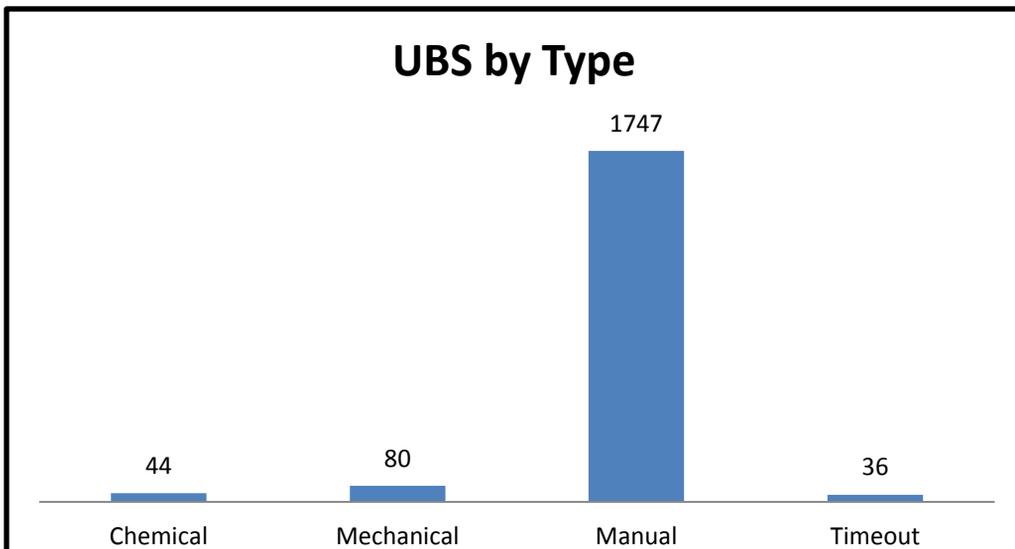
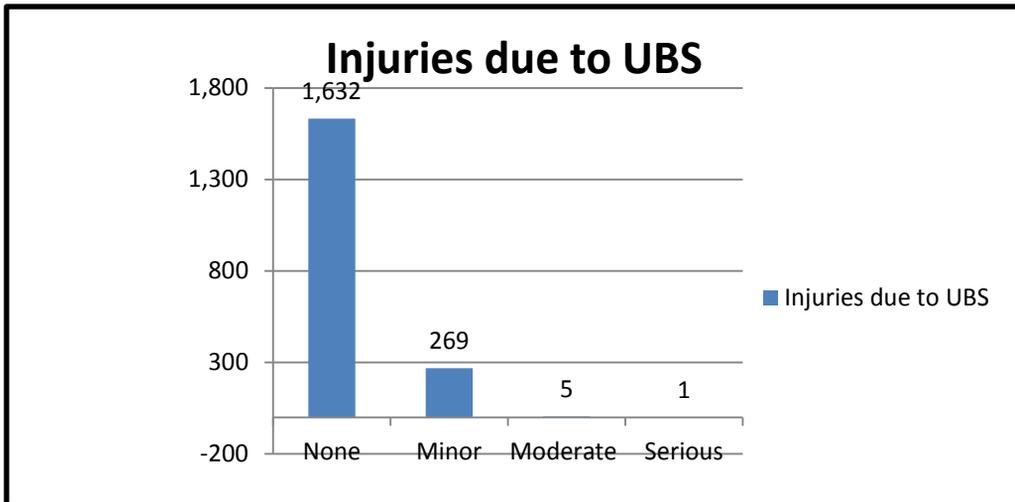
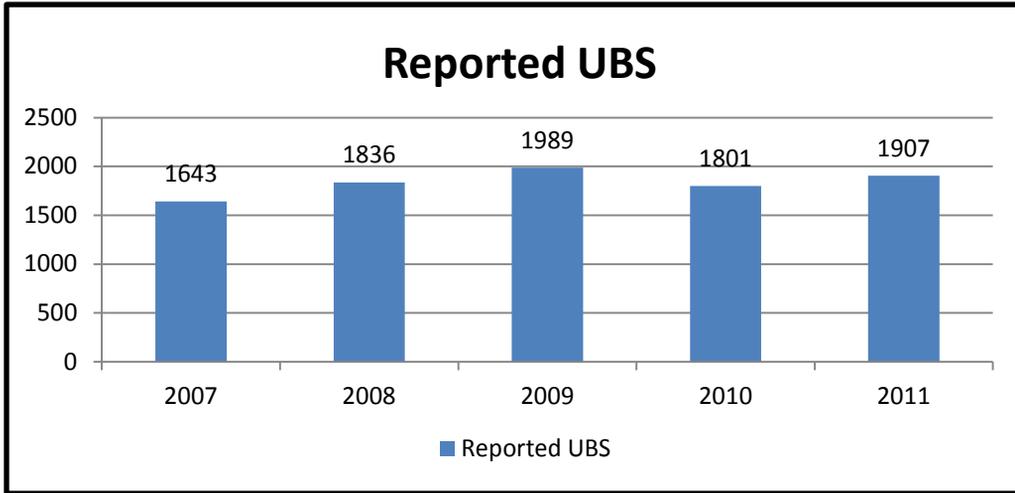
Communicating pain/discomfort
Mental health issues
Alcohol usage

Several cases described the two individuals as being like family and having a sibling "love/hate" relationship. The number of cases involving alcohol usage or Alzheimer's Disease listed as a factor have decreased since 2010.

Physical Acts - Prevention measures:

<i>Counseling for aggressor;</i>	<i>Changes to Behavior Support Program;</i>
<i>Medication changes;</i>	<i>Law enforcement speaking with aggressor;</i>
<i>Move either to another room/house</i>	<i>Additional supervision;</i>
<i>Different lunch/break times;</i>	<i>Change transportation or seating on bus/van;</i>
<i>Securing property;</i>	<i>Set times to use phone, watch tv, radio;</i>
<i>Buying additional televisions;</i>	<i>Increased exercise;</i>
<i>Staff communication;</i>	<i>Apology by the aggressor.</i>

Unapproved behavior support. "Unapproved behavior support" means the use of any aversive strategy or intervention implemented without approval by the human rights committee or behavior support committee or without informed consent.

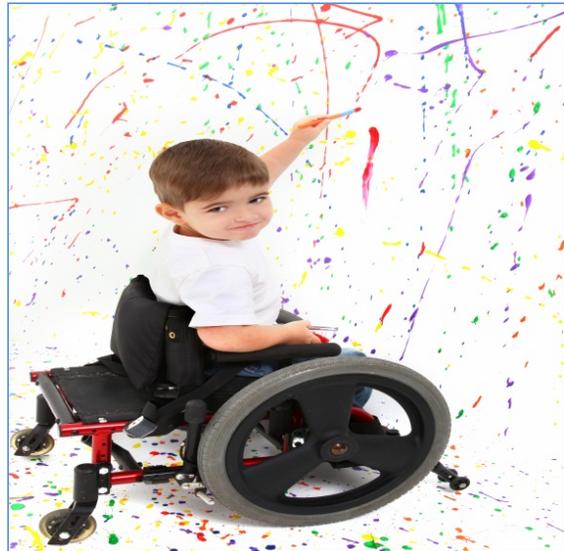


Causes and Contributing Factors to Unapproved Behavior Supports:

- Staff not following preventative measures because they believe the intervention will not have the suspected outcome
- Lack of training on plans
- Power Struggle
- Staffing
- Lack of Management Support

Prevention Planning:

- Proactive interventions to protect health & safety BSP
- Quality Training
- Incident reporting – address the concerns at its earliest onset
- Debriefing- Why or what lead to the incident?
- Team meetings/prevention
- Management follow through/supports
- Assessments
- Environment
- Staff Coverage
- Administrative Oversight



Positive Culture Initiative

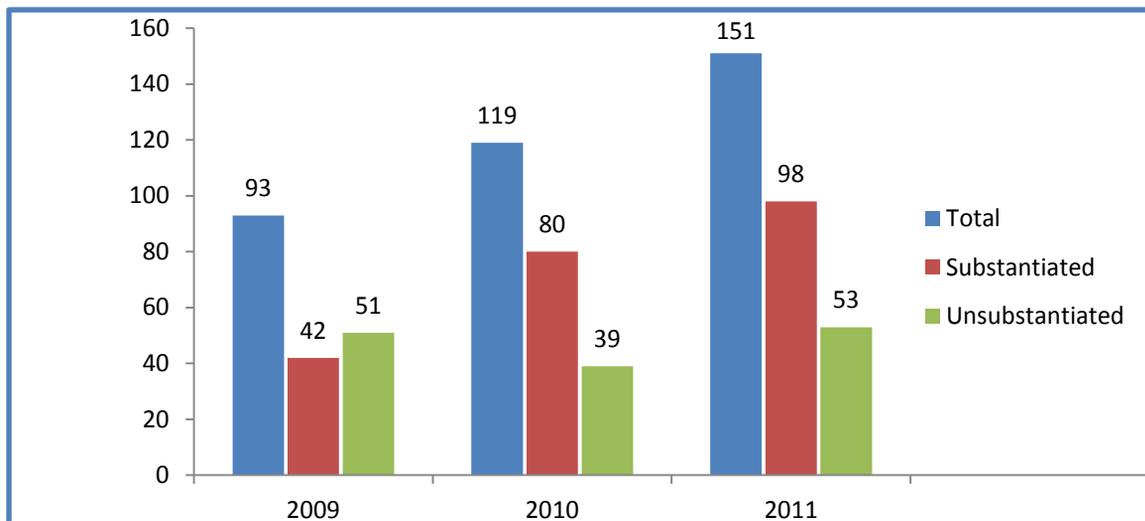
Learn more about creating a Positive Culture Initiative at <http://dodd.ohio.gov/pci>

A positive culture is an intentional way of supporting all people within our communities that focuses on creating healthy relationships and acknowledging the unique gifts that each brings to those relationships. It is about making the shift in thinking away from power, control and coercion in language and actions, and toward affirmation, unconditional acceptance and encouragement.

There are three different definitions of Failure to Report with three different evidentiary standards. The criminal offense of Failure to Report contained in Ohio Revised Code Section 5123.61 Which can either be a misdemeanor or a felony depending on the severity of the offense. Criminal offenses must be proven beyond a reasonable doubt. The Abuser Registry definition is found in R.C. 5123.50. It requires clear and convincing evidence and also considers extenuating factors in certain cases. The major unusual incident (MUI) definition in Ohio Administrative Code 5123:2-17-02(C)(13)(e) is the broadest of the three definitions and only requires a preponderance to substantiate. The MUI definition is that a:

Mandatory reporter has reason to believe that an individual has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse (including misappropriation) or neglect and does not immediately report it to law enforcement or the county board. For individuals served by developmental centers it is law enforcement or the department.

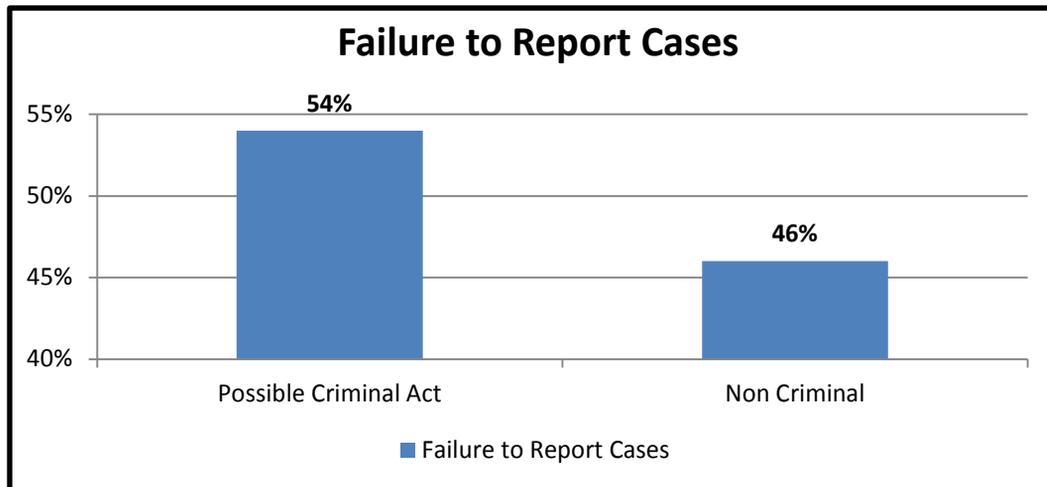
The substantiation rate for Failure to Report was 65 % in 2011 which is a decrease of 2% from 2010.



A review of the substantiated cases shows that there were various reasons given by the person for failing to report:

- *They were afraid for their job, themselves, or their family.*
- *They had become accustomed to reports or seeing neglect or violence.*
- *Lack of recognition of abuse/neglect.*
- *The victim always “cries wolf” so they are not believed.*
- *The victim is not seen as a victim, they are seen as difficult to work with.*
- *They are friends with abuser- don’t want to get them in trouble.*
- *The abuser is going through a rough time – it was a one time event.*
- *Someone else will report it – they are required to so I don’t have to tell anyone.*
- *Miscommunication of who will report abuse/neglect. They are new and hesitant to report anything.*
- *Want to report to specific person who is not there – on vacation, different shift.*
- *Discount individual’s allegation; attribute injuries/behaviors to something else.*
- *Didn’t want to alienate family/guardian; they would pull individual from services.*

In 2011, in 54% of the substantiated cases, the failure to report was considered a possible criminal act and law enforcement was contacted. Law enforcement conducted the investigation in 12 of the 98 (12%) of the cases. Many times the abuser would be described as “rough” or “mean” to everyone – individuals and staff alike. Other staff may even be afraid of what he/she would do if they told.



There were times when the mandatory reporter did not want to follow the known reporting procedure and instead called someone else that they trusted – a co-worker, a family member, or a supervisor on another shift. There were very few cases in which there was a true miscommunication of who was going to report the allegation. More likely is that there were multiple mandatory reporters and no one reported it. Some even tried to explain that - I thought the abuser would report it themselves. A review of the cases shows that in 58% of the substantiated cases there was more than one person who failed to report the abuse/neglect.

Prevention measures included:

- Developing on-call procedures to recognize reports of abuse.
- Providing staff with a 24-emergency line to access supervisory support.
- Many times the person who failed to report was fired.
- Even in cases with only one person who failed to report, many providers chose to train all staff in the home or agency about being a mandatory reporter.



Medical emergency. "Medical emergency" means an incident where emergency medical intervention is required to save an individual's life (e.g., Heimlich maneuver, cardiopulmonary resuscitation, intravenous for dehydration).

- *There were 631 medical emergencies reported in 2011 which reflects an increase from 596 in 2010.*
- *Choking-Use of Heimlich and Back Blows were used 289 and 75 times respectively during 2011. These interventions were successful in all but 6 incidents in which an individual died as a result of choking.*
- *Dehydration continues to be one of the leading causes of medical emergencies with 65 reported MUIs in 2011 which is an increase of 4.*
- *Tube Issues, blood sugar levels, and impaired respiration comprised the next three highest categories with 34, 32, and 20 respectively.*

The chart below provides the number and type of medical emergencies.

2011 Medical Emergencies	Count
Allergic Reaction	11
Altered State	3
Back Blows	75
Blood Pressure	5
Blood Sugar Levels	32
Chest Compressions/CPR	9
Chest Pains	3
Dehydration/Volume Depletion	65
Emesis (vomit, diarrhea)	15
Heimlich Maneuver	289
Impaired Respiration	20
Infection	20
Ingestion-PICA	7
Kidney	2
Other	15
Placed Item in Orifice	1
Pneumonia and Influenza	6
Seizure	18
Tube Issues	34
Unexplained Bleeding	1
Total	631

"Unscheduled hospitalization" means any hospital admission that is not scheduled unless the hospital admission is due to a condition that is specified in the individual service plan or nursing care plan indicating the specific symptoms and criteria that require hospitalization.

The Major Causes of Unplanned Hospitalizations in 2011 were:	
Pneumonia and Influenza (816) 18%	Chest Pains (156) 4%
Psychiatric (724) 16%	Heart Problems (132) 3%
Infection (550) 12%	Impaired Respiration (131) 3%
Seizures (236) 5%	Bowel Obstruction (127) 3%

Points to note:

There were 4,426 unplanned hospitalizations in 2011 which is a slight increase of 2% over the previous year. As in the past, unscheduled hospitalizations represent the largest category of all reported MUIs at 23%. Unplanned psychiatric hospitalizations account for 724 (16%) of all unplanned hospitalizations while medical hospitalizations make up 3,702 (84%).

The chart below represents the reasons for hospitalizations from 2005-2011

	2005	2006	2007	2008	2009	2010	2011
Abdominal Pains	154	199	97	78	67	58	59
Abnormal Blood Levels				20	45	111	62
Absent Pulse	4	2	1	3	1	3	2
Allergic Reaction	17	19	10	10	9	13	13
Altered State	234	215	178	158	122	106	89
Baclofen Pump Issues							4
Blood Clots				25	57	61	48
Blood Pressure	0	23	60	66	58	38	53
Blood Sugar Levels	89	91	55	56	50	50	41
Bowel Obstruction	130	136	117	115	119	137	127
Cancer						29	18

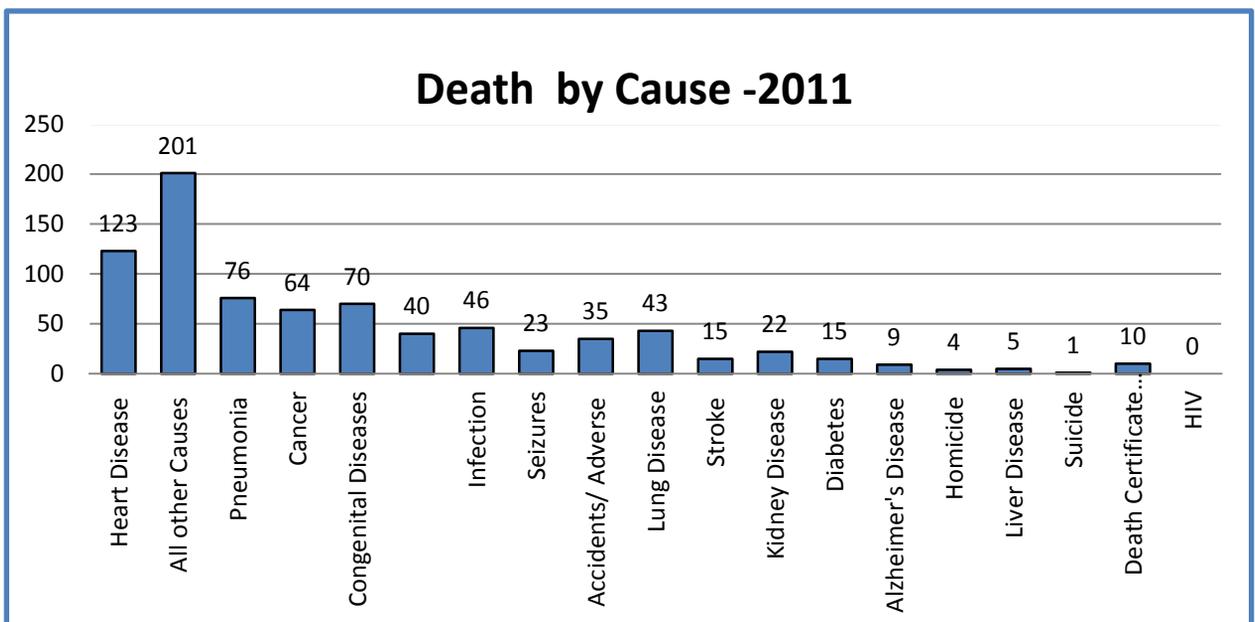
The chart below represents the reasons for hospitalizations from 2005-2011

	2005	2006	2007	2008	2009	2010	2011
Chest Pains	315	306	160	165	169	158	156
Decubitus Ulcer	0	0	0	0	0	0	5
Dehydration	235	212	112	116	103	93	91
Edema	0	0	0	0	0	0	9
Emesis	298	289	165	136	108	112	80
Gallbladder	48	42	24	224	38	47	47
Headache	0	0	0	0	0	0	4
Heart Problems	35	2	86	80	135	141	132
Impaired Respirations	440	378	199	173	149	205	131
Infection	584	564	391	388	513	661	550
Ingestion - PICA	9	13	1	4	10	10	7
Kidney	74	79	33	40	64	69	76
Med Error	10	4	0	0	2	3	0
Observation-Evaluation						159	218
Other**	1110	1212	573	605	756	159	464
Placed Item in Orifice	4	1	1	2	5	3	1
Pneumonia	1001	943	563	632	817	701	816
Seizure	482	465	224	269	256	235	236
Shunt	0	1	2	7	18	15	7
Stroke	59	43	46	40	29	36	23
Syncope						12	29
Tube Issues	41	64	34	38	25	68	46
Unexplained Bleeding	111	102	22	72	66	90	35
Unknown	23	14	6	4	0	0	0
Psychiatric	1144	1134	570	614	643	698	724
Totals	6651	6553	3730	3940	4434	4320	4424

**Other reasons for hospitalization include: elevated temperature, elevated blood levels, surgery, etc. The MUI Unit will continue to make changes to the Incident Tracking System to capture specific data for hospital admissions.

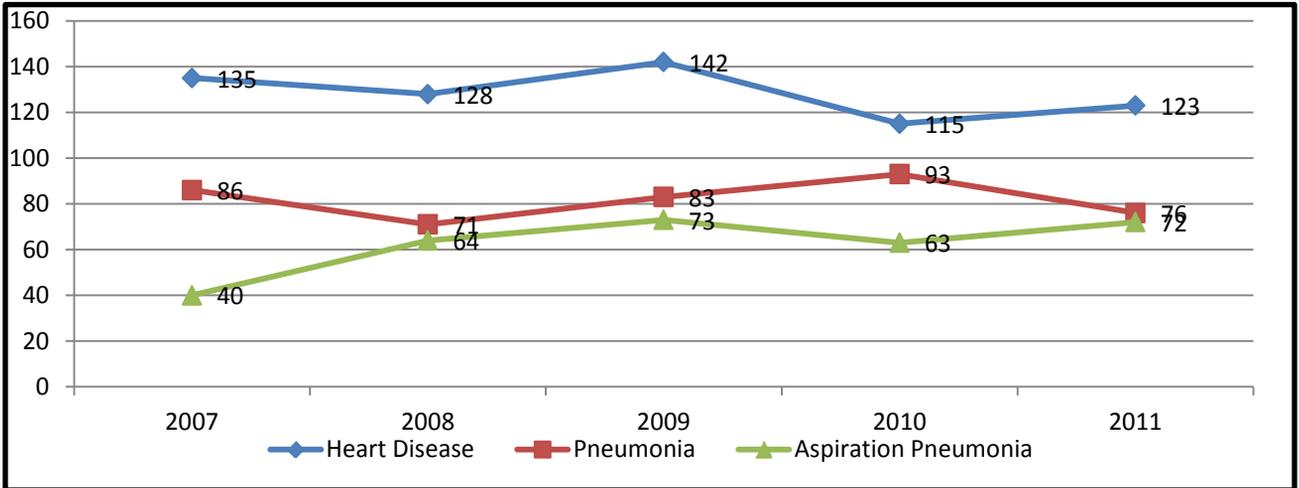
There were 802 reported deaths in 2011 resulting in a crude mortality rate of 888. (per 100,000) compared with Centers for Disease Control preliminary 2010 data which was 798.7 for overall deaths in the general population. The following is a summary of data collected on deaths with individuals with disabilities in Ohio.

- Heart disease continues to be the leading cause of death for Ohioans with disabilities (15%) as well as the general population.
- The average age of the 802 individuals who died in 2011 was 50.42 years compared to the average populations life expectancy is 78.5 years (CDC).
- Pneumonia and aspiration pneumonia continue to make up the next largest causes of death.
- Men continued to have a higher mortality rate (54%) than women (46%).
- Individuals residing in a licensed facility had the highest mortality rate. Often individuals who reside in licensed facilities have higher medical needs.
- Incidents of cancer related deaths accounted for 8 % of all individuals who died in the system.
- Of the 802 reported deaths in 2011, there were 35 identified as adverse (accidental, homicide, suicide). Adverse deaths accounted for 4.36 percent of all death reports. There was a slight decrease in adverse deaths over the past year.
- Falls accounted for 7 deaths in 2011 which is a decrease of 4 deaths caused by falls in 2010.
- In 2011, 6 people died due to choking. This was a decrease of 4 from 2009 and the same as 2010.



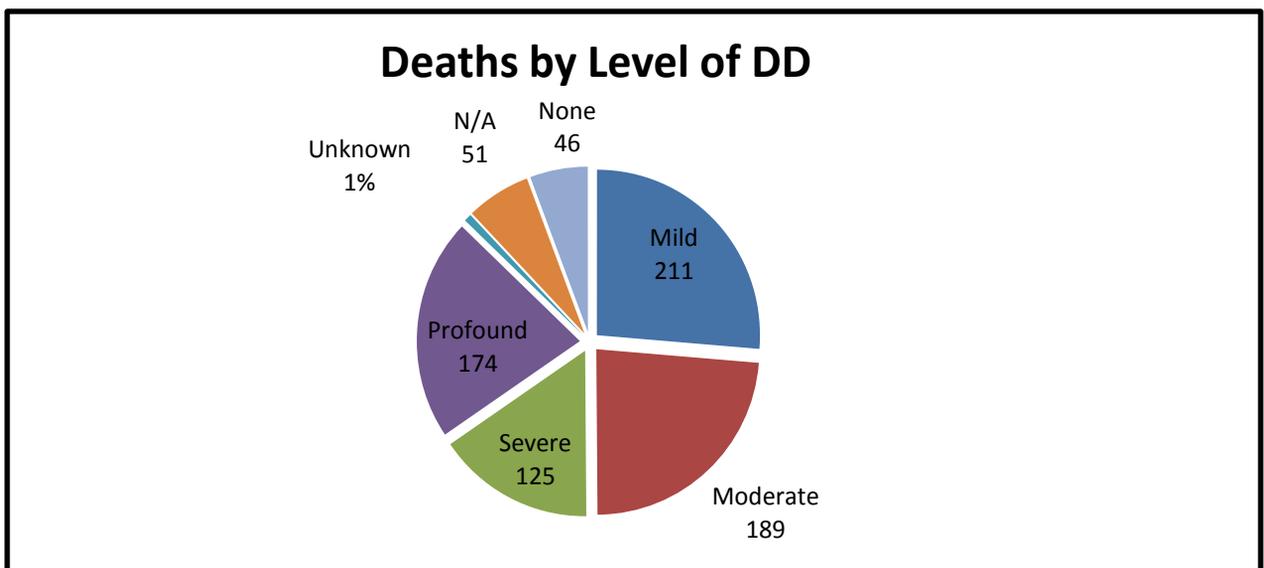
All other causes of deaths listed in 2011 included: bowel obstruction, Parkinson, Sleep Apnea, Respiratory Failure, etc. The Department will continue to collect specific data on causes of data by making enhancements to the Incident Tracking System.

Leading Causes of Death from 2007-2011



A three year review of the leading causes of death for Ohioans with disabilities served in our system.

Ranking	2011	Counts	2010	Counts	2009	Counts
1	All Other Causes*	201	All Other Causes	138	All Other Causes	123
2	Heart Disease	123	Heart Disease	120	Heart Disease	115
3	Pneumonia	76	Cancer	83	Pneumonia	93
4	Cancer	64	Pneumonia	66	Cancer	66
5	Congenital Diseases	70	Congenital Diseases	61	Aspiration Pneumonia	65
6	Aspiration Pneumonias	40	Aspiration Pneumonia	52	Congenital Diseases	55



*Other causes of death in 2011 include: bowel obstruction, surgical complications or cause was not known at the time of this report.

Cause	Number in 2011	Living Arrangement	Number in 2011	% of 2011 Pop. Served	% of total Adverse Deaths
Choking	6	Family Home	12	69%	34
Vehicle Accidents	7	ICF or Licensed Facility	7	8%	20
Drowning	6	Own Home/Apt	4	14%	11
Fall	7	I/O Waiver	7	8%	20
Fire	1	Nursing Facility	4	1%	12
Homicide	1	Foster Care/Other	1	2%	3
Suffocation	0	Total Adverse Reaction Deaths 2011 = 35 Total Deaths for 2011 = 802 Adverse deaths = 4.4% of all deaths			
SIDS	0				
Medication Reaction	0				
Drug Overdose	2				
Other Accidents	3				
Suicide	2				

Cause	Number in 2010	Living Arrangement	Number in 2010	% of 2010 Pop. Served	% of total Adverse Deaths
Choking	6	Family Home	15	69%	38
Vehicle Accidents	9	ICF or Licensed Facility	13	10%	33
Drowning	2	Own Home/Apt	0	14%	0
Fall	11	I/O Waiver	11	14%	28
Fire	0	Nursing Facility	1	1%	25
Homicide	4	Foster Care/Other	0	2%	0
Suffocation	0	Total Adverse Reaction Deaths 2010 = 40 Total Deaths for 2010 = 735 Adverse deaths = 5.4% of all deaths			
SIDS	0				
Medication Reaction	1				
Drug Overdose	2				
Other Accidents	5				
Suicide	0				

Cause	Number in 2009	Living Arrangement	Number in 2009	% of 2009 Pop. Served	% of total Adverse Deaths
Choking	10	Family Home	13	66%	37.1
Vehicle Accidents	2	ICF or Licensed Facility	11	12%	34.3
Drowning	2	Own Home/Apt	1	14%	2.9
Fall	12	I/O Waiver	7	14%	11.4
Fire	2	Nursing Facility	3	2%	11.4
Homicide	5	FosterCare/Other	1	2%	2.9
Suffocation	0	Total Adverse Reaction Deaths 2009 = 36 Total Deaths for 2009 = 755 Adverse deaths = 4.7 % of all deaths			
SIDS	0				
Medication Reaction	0				
Drug Overdose	2				
Other Accidents	1				
Suicide	0				

(13) "Major unusual incident" (MUI) means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or safety of an individual may be adversely affected or an individual may be placed at a reasonable risk of harm as listed in this paragraph, if such individual is receiving services through the MR/DD service delivery system or will be receiving such services as a result of the incident. Major unusual incidents (MUIs) include the following:

(a) Abuse. "Abuse" means any of the following when directed toward an individual:

(i) Physical abuse. "Physical abuse" means the use of physical force that can reasonably be expected to result in physical harm or serious physical harm as those terms are defined in section 2901.01 of the Revised Code. Such force may include, but is not limited to, hitting, slapping, pushing, or throwing objects at an individual.

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

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

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

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

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

(e) Failure to report. "Failure to report" means that a person, who is required to report pursuant to section 5123.61 of the Revised Code, has reason to believe that an individual has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse (including misappropriation) or neglect of that individual, and such person does not immediately report such information to a law enforcement agency, a county board, or, in the case of an individual living in a developmental center, either to law enforcement or the department. Pursuant to division (C)(1) of section 5123.61 of the Revised Code, such report shall be made to the department and the county board when the incident involves an act or omission of an employee of a county board.

(f) Known injury. "Known injury" means an injury from a known cause that is not considered abuse or neglect and that requires immobilization, casting, five or more sutures or the equivalent, second or third degree burns, dental injuries, or any injury that prohibits the individual from participating in routine daily tasks for more than two consecutive days.

(g) Law enforcement. "Law enforcement" means any incident that results in the individual being charged, incarcerated, or arrested.

(h) Medical emergency. "Medical emergency" means an incident where emergency medical intervention is required to save an individual's life (e.g., Heimlich maneuver, cardiopulmonary resuscitation, intravenous for dehydration).

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

(j) Missing individual. "Missing individual" means an incident that is not considered neglect and the individual cannot be located for a period of time longer than specified in the individual service plan and the individual cannot be located after actions specified in the individual service plan are taken and the individual cannot be located in a search of the immediate surrounding area; or circumstances indicate that the individual may be in immediate jeopardy; or law enforcement has been called to assist in the search for the individual.

(k) Neglect. "Neglect" means when there is a duty to do so, failing to provide an individual with any treatment, care, goods, supervision, or services necessary to maintain the health or safety of the individual.

(l) Peer-to-peer acts. "Peer-to-peer acts" means acts committed by one individual against another when there is physical abuse with intent to harm; verbal abuse with intent to intimidate, harass, or humiliate; any sexual abuse; any exploitation; or intentional misappropriation of property of significant value.

(m) Prohibited sexual relations. "Prohibited sexual relations" means an MR/DD employee engaging in consensual sexual conduct or having consensual sexual contact with an individual who is not the employee's spouse, and for whom the MR/DD employee was employed or under contract to provide care at the time of the incident and includes persons in the employee's supervisory chain of command.

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

(o) Unapproved behavior support. "Unapproved behavior support" means the use of any aversive strategy or intervention implemented without approval by the human rights committee or behavior support committee or without informed consent.

(p) Unknown injury. "Unknown injury" means an injury of an unknown cause that is not considered possible abuse or neglect and that requires treatment that only a physician, physician's assistant, or nurse practitioner can provide.

(q) Unscheduled hospitalization. "Unscheduled hospitalization" means any hospital admission that is not scheduled unless the hospital admission is due to a condition that is specified in the individual service plan or nursing care plan indicating the specific symptoms and criteria that require hospitalization.